Supreme Court, U.S.
FILED
DEC 13 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 89-941

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C.; B.I. RADIOLOGY ASSOCIATES; BOOTH RADIOLOGY CONSULTANTS; CENTRAL GENERAL RADIOLOGISTS; COLUMBIA PRESBYTERIAN RADIOLOGISTS; CORNELL RADIOLOGY GROUP; DEMETER RADIOLOGICAL ASSOCIATES, P.C.; NATHAN GEFFEN, M.D., P.C.; GRAMERCY RADIOLOGY GROUP, P.C.; GREENE COUNTY RADIOLOGY CONSULTANTS, P.C.; H.S.S. RADIOLOGISTS; HAECOM RADIOLOGY

(For Continuation of Caption See Inside of Cover)

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

NORTON L. TRAVIS*
GARFUNKEL, WILD & TRAVIS, P.C.
175 Great Neck Road
Great Neck, New York 11021
(516) 466-3090

DANIEL P. LEVITT
REID & PRIEST
40 West 57th Street
New York, New York 10019
(212) 603-2000
Attorneys for Petitioners

**Counsel of Record*

ASSOCIATES; HUDSON VALLEY RADIOLOGISTS, P.C.; ISLAND RADIOLOGICAL ASSOCIATES, P.C.; DOO JOE KIM, M.D., P.C.; KINGS COUNTY RADIOLOGY ASSOCIATES, P.C.; KINGS HIGHWAY RADIOLOGY ASSOCIATES, P.C.; KINGSBROOK RADIOLOGY, P.C.; MAIMONIDES RADIOLOGY ASSOCIATES, P.C.; ORLANDO L. MANFREDI, M.D., P.C.; MEDICAL ARTS RADIOLOGICAL GROUP, P.C.; MEETH RADIOLOGY ASSOCIATES; ALBERT B. MESSINA, M.D. and ARIE L. LIEBESKIND, M.D.; MEMORIAL HOSPITAL RADIOLOGY; METHODIST RADIOLOGY ASSOCIATES, P.C.; MONTEFIORE RADIOLOGY ASSOCIATES; MOUNT SINAI RADIOLOGY ASSOCIATES; MOUNT VERNON HOSPITAL RADIOLOGY ASSOCIATES, P.C.; NASSAU DIAGNOSTIC IMAGING AND RADIATION ONCOLOGY ASSOCIATES, P.C.; NEW ROCHELLE RADIOLOGY ASSOCIATES, P.C.; NORTHERN WESTCHESTER RADIOLOGY SERVICES, P.C.; NUCLEAR MEDICINE SERVICE; NYU RADIOLOGY ASSOCIATES; H. PAREKH, M.D., P.C.; RADIOLOGIC ASSOCIATES, P.C.; RADIOLOGICAL ASSOCIATES OF HEMPSTEAD; RADIOLOGICAL GROUP OF PHELPS MEMORIAL HOSPITAL CENTER; RADIOLOGICAL HEALTH SERVICES, P.C.; RADIOLOGY ASSOCIATES OF ST. FRANCIS; DIVISION OF DIAGNOSTIC RADIOLOGY-NORTH SHORE UNIVERSITY HOSPITAL; DIVISION OF CAT SCANNING-NORTH SHORE UNIVERSITY HOSPITAL; DIVISION OF NUCLEAR MEDICINE-NORTH SHORE UNIVERSITY HOSPITAL; RADIOLOGY GROUP AT ST. VINCENT'S, P.C.; RADIOLOGY SPECIALISTS OF KINGSTON, P.C.; RAMAPO RADIOLOGY ASSOCIATES, P.C.; RICHMOND RADIOLOGICAL SERVICES, P.C.; ROCKLAND RADIOLOGIC GROUP, P.C.; ST. BARNABAS RADIOLOGICAL ASSOCIATES, P.C.; ST. JOHN'S RADIOLOGICAL ASSOCIATES, P.C.; ST. JOSEPH'S RADIOLOGY, P.C.; SEA SHORE RADIOLOGY, P.C.; P. SPADAVECCHIA, M.D., P.C.; SUFFOLK RADIOLOGY ASSOCIATES, P.C.; SULLIVAN COUNTY RADIOLOGICAL ASSOCIATES; PAUL TARTELL, M.D., CRAIG J. YOUNER, M.D., P.C.; ULSTER RADIOLOGIC ASSOCIATES, P.C.; UNIVERSITY RADIOLOGY ASSOCIATES, P.C.; and WAKEFIELD RADIOLOGY, P.C.,

Petitioners,

—v.—

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Respondent.

QUESTIONS PRESENTED

1. Whether a monopolist may with impunity seek to preserve or enhance its monopoly, through threats of economic reprisals, in order to compel unwilling "sellers" to provide the services of unwilling third-parties, which services the monopolist does not normally buy and which the seller does not normally sell?

2. Whether such a monopolist may evade traditional bilateral negotiations with the "true sellers" of the desired services by coercing unwilling third parties, over whom it has monopoly power, to obtain the services for the monopolist on terms not otherwise available to it?

3. Whether in a "rule of reason" antitrust case, a district judge is free to choose between two sharply conflicting characterizations of a defendant's behavior, and, in the face of desposition testimony and "smoking gun" documents showing anti-competitive intent and coercive misconduct, grant summary judgment based upon the judge's decision to accept the benign alternative characterization advocated by the defendant?

TABLE OF CONTENTS

	Page
Questions Presented	i
Table of Authorities	v
Opinions Below	1
Jurisdiction	1
Statutes Involved	1
Statement of the Case	2
I. Factual Background	2
a. Respondent monopolizes the Downstate hospital insurance market, but is relatively weak in the competitive market for medical insurance	2
b. Empire perceives that direct billing by self-employed hospital-based physicians threatens its positions in both markets	2
c. Empire misuses its monopoly power to coerce the Hospitals, against their self-interest, into enforcing a concerted ban on direct billing	5
II. The Proceedings Below	7
A. The original district judge rejects Empire's argument	8
B. A newly assigned district judge accepts the same arguments her judicial predecessor had rejected, granting summary judgment in favor of respondent	10

Page

C. The Court of Appeals affirms 11

Reasons for Granting the Writ 11

I. The decision below conflicts with and erodes this Court's decision in *Aspen Skiing* and *Lorain Journal*, which impose essential limitations on misuse of market power 12

II. The decision below conflicts with the First Circuit's *Kartell* decision, and dangerously expands the license afforded purchasers with monopoly power 14

III. The decision below departs from sound summary judgment practice, and in this respect also conflicts with and erodes *Aspen Skiing* and *Lorain Journal* 17

Conclusion 20

TABLE OF AUTHORITIES

Cases	Page
Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982)	13, 14
Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S 585 (1985)	12, 13, 17, 18
Ball Memorial Hosp. v. Mutual Insurance, 784 F.2d 1325 (7th Cir. 1986)	15n
Barry v. Blue Cross of California, 805 F.2d 866 (9th Cir. 1986)	15n
Kartell v. Blue Shield of Massachusetts, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985)	*passim*
Lorain Jounal Co. v. United States, 342 U.S. 143 (1951)	12, 13, 17, 18
Matsushita Electric Ind. Co. v. Zenith Radio Corp., 475 U.S. 574 (1986)	17, 18
National Society of Professional Engineers v. United States, 435 U.S. 679 (1978)	18
Poller v. Columbia Broadcasting System, 368 U.S. 464 (1962)	18
Sausalito Pharmacy v. Blue Shield of California, 544 F. Supp. 230 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982)	15n
United States v. Aluminum Company of America, 148 F.2d 416 (2nd Cir. 1945)	19

Page

United States v. General Motors Corp., 384 U.S. 127 (1966) 16

United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940) 14

Statutes

15 U.S.C. Section 1 ..... 1, 8, 16

15 U.S.C. Section 2 ..... 1, 8, 12

Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

Petitioners respectfully request that a writ of certiorari issue to review the decision and judgment of the United States Court of Appeals for the Second Circuit, entered on September 14, 1989, affirming a decision of the Southern District of New York granting summary judgment in favor of respondent against petitioners' federal antitrust claims.

OPINIONS BELOW

The opinion of the Court of Appeals, not officially reported at 884 F.2d 707, is reprinted at pages A-3 through A-4 of the appendix hereto.[1] The opinion of the District Court granting summary judgment to respondent is reported at 707 F. Supp. 708, and is reprinted at A-6 through A-23. An earlier opinion, by the district court judge to whom the case was originally assigned, and which sustained petitioners' position, is reported at 659 F. Supp. 132; it is reprinted at A-26 through A-36.

JURISDICTION

The judgment of the Court of Appeals was entered on September 14, 1989. This Court has jurisdiction to review that judgment by writ of certiorari pursuant to 28 U.S.C. Section 1254(1).

STATUTES INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. Section 1, provides in relevant part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . is declared to be illegal . . . .

---

[1] A-____ denotes reference to the appendix hereto. JA __ denotes reference to the joint appendix filed in the Court of Appeals.

Section 2, 15 U.S.C. Section 2, provides in relevant part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize . . . shall be deemed guilty of a felony . . . .

STATEMENT OF THE CASE

I. Factual background:

a. Respondent monopolizes the Downstate hospital insurance market, but is relatively weak in the competitive market for medical insurance

Approximately 11 million people live in the 17 counties in the metropolitan New York City ("Downstate") area. Some 9 million of them, or over 80 per cent, have insurance against hospital bills under the Blue Cross plan offered by respondent Empire Blue Cross and Blue Shield, Inc. ("Empire"). (JA 543-51) In contrast, fewer than a third subscribe to Empire's Blue Shield insurance plan which covers physicians' bills. (JA 536.1-536.3)

This case arises out of a decision made in April 1984 by Empire to stomp out a perceived threat to its monopoly of the Downstate market for hospital insurance. At the same time, Empire determined to leverage its hospital insurance monopoly to shore up its relatively weak position in the far more competitive Downstate market for medical insurance.

b. Empire perceives that direct billing by self-employed hospital-based physicians threatens its positions in both markets

As reflected in its own board minutes, and as confirmed in deposition testimony from key Empire officials, the perceived threat to Empire's market share emerged from the fact that for several years one hospital-based medical specialist after another had converted from salaried employee status to that of self-employed private practitioner.

So long as hospital-based physicians functioned as salaried hospital employees, they did not send bills to patients. Instead, the cost of their professional services was included in hospital overhead and reimbursed by patients or their hospital insurers, including Empire's Blue Cross plan, directly to the Downstate Hospitals – in the same manner as are other elements of hospital overhead like the undifferentiated cost of facilities, supplies, administration, nursing, sanitation, etc.

Fundamental change came in the 1970s. The new federal Medicare program explicitly provided that, to the extent hospital-based physicians functioned as self-employed private practitioners rather than salaried employees, they were now able to bill Medicare patients directly for their professional services on a fee-for-service basis. In consequence, hospital-based medical specialists everywhere began converting to self-employed status – and for the first time began billing patients.

The Nation's anesthesiologists were the first to convert. When they began to direct bill patients, Blue Cross organizations everywhere, including Empire's Blue Cross plan, recognized this change in economic status and stopped reimbursing hospitals for the services of these now self-employed practitioners. In consequence, the anesthesiologists' professional services rendered to Blue Cross subscribers were no longer covered by Blue Cross, but by the patient's medical insurance – Blue Shield or one of its competitors.

The Nation's hospital-based radiologists[2] soon followed suit and themselves began converting to self-employed private-practitioner status. When this occurred, the same rule applied – the Blue Cross plans stopped reimbursing hospitals for the radiologists' services and, instead, coverage for these services switched to the

---

[2] Radiologists are licensed physicians who have completed the required special training and residency to quality in that specialty. The *diagnostic* radiological services they render – their expert interpretations of radiological examinations (e.g., CT and MRI scans, sonograms, fluoroscopies and x-rays) – frequently constitute the primary and decisive medical basis for determining the course of a patient's care and treatment. Their *therapeutic* radiological services are used in the treatment and cure of many diseases, including cancer.

Blue Shield or other medical insurance plans — everywhere, that is, except in Downstate New York.[3]

At key April 1984 Empire board meetings, senior management concluded that the Blue Cross organizations in the other 49 states (and in the 45 New York counties outside the Downstate area) had erred in ever allowing these new private practitioners to direct bill patients. They concluded that they had themselves erred in allowing anesthesiologists to direct bill. And they concluded they would not repeat the "error" by permitting radiologists to do so.

Their motive was not (as assumed by the courts below) to promote cost-containment or any high-minded notion. Instead, it was pure economics. More precisely, their perception — as stated in the minutes of those board meetings — was that stripping away Blue Cross coverage for such hospital-based medical services would

> reduce the value of our product and imperil our market share. (JA 555)
>
> • • •
>
> The effect on our share of market, and the tendency toward further fragmentation of the system are additional serious problems inherent in this option. (JA 562)
>
> • • •
>
> The ultimate question comes down to whether we can continue to include these costs under the Blue Cross contract or abandon the field [of medical insurance] to others? (JA 555)

They reasoned that stripping away such coverage from their Blue Cross hospital insurance product would diminish its attractiveness. Moreover, because Blue Shield had only one-third as many subscribers as Blue Cross, two-thirds of this claims business would go to its competitors.

---

[3] A 1987 study by the American College of Radiology, which filed an amicus brief in the Court of Appeals on behalf of petitioners, confirmed that no other insurance carrier in the country prohibits self-employed hospital-based radiologists from billing patients for their professional services.

c. Empire misuses its monopoly power to coerce the Hospitals, against their self-interest, into enforcing a concerted ban on direct billing

How, then, to prevent the logical consequence of the radiologists' converson to private practitioner status – direct billing of Blue Cross subscribers? As an insurer of hospital bills, Blue Cross deals with hospitals and their overhead, not physicians and their services to individual patients. And whereas its Blue Shield affiliate does regularly negotiate with physicians, it lacked the economic clout to dissuade the radiologists – who were already direct billing their Medicare, Medicaid, commercially insured, and all other private patients – from insisting on their right to direct bill those patients who happened to be Blue Cross subscribers.

The answer lay in Empire's enormous economic power over the Downstate Hospitals. Its 9 million Blue Cross subscribers generate $1 billion of annual revenues to the Hospitals. (JA 274) Dropping a hospital from the list of participating Blue Cross hospitals would be catastrophic. And given the Hospitals' precarious financial condition, informal delays in payment or slow responses to the administrative "appeals" which Hospitals file in reimbursement disputes would seriously impact hospital cash flow. In addition, Blue Cross as a matter of discretion makes loans or advances to assist hospitals with capital needs. (JA 714.50)

Moreover, respondent Empire wears a second hat. For most of the Downstate Hospitals, it serves as the local Medicare Part A Intermediary – meaning that it is "paymaster" for another $1.6 billion of annual hospital revenues. (JA 407-08) This puts respondent Empire in control of over one-half (and in some instances much more than that) of the Hospitals' total cash flow. (JA 407-08, 482)

At deposition, hospital administrators explained that the Hospitals' economic self-interest favored direct billing by hospital-based physicians, including radiologists. As one, with 20 years of experience in the Downstate area, testified:

> Number one, the hospitals no longer have to pay a salary to radiologists.

> Number two, the fee income derived by the radiologist is utilized not only to pay the radiologists but also to buy equipment for the radiology department, which the hospital might not have been able to afford without the fee-for-service revenue . . . .
>
> A third advantage to the hospital is the ability to attract and retain qualified physicians who are able to bill on a professional basis as do their peers, other physicians. (JA 430-31)

But the Hospitals were not free to act according to their will. On the contrary, they have been coerced by Empire to disregard their own self-interest and enforce Empire's ban on direct billing. They explained their fear to do otherwise in sworn deposition testimony. In the words of four hospital chief financial officers:

> [W]e have no choice . . . we are concerned about the revenge factor, that might take place from Blue Cross . . . . We certainly know that Blue Cross has the power to affect our revenues. (JA 476-82)
>
> • • •
>
> [I]f the hospital decided to do something differently, then there would be some potential problems with Blue Cross given their leverage on how much dollars they controlled which flowed into the institution. . . . [T]hat is to say, if you do allow the physicians to bill directly, the Hospital is in jeopardy of being cut off by Blue Cross. (JA 489)
>
> • • •
>
> It was basically a mandate from Blue Cross. (JA 493)
>
> • • •
>
> I don't think Richmond Memorial has had a choice of having an opinion in the matter. We've been told by a very powerful organization that this is the way life is, and we have chosen to just accept it. (JA 497)

The Hospitals' fears were well-founded. Senior Empire officials – the very individuals who control the lifeblood of the Hospitals' existence – blithely testified at deposition that if the Hospitals did not comply, they would invoke "sanctions," including terminating a Hospital as a Blue Cross participant, cutting off a Hospital's cash flow, or "anything else short of death." (JA 714.54)

Moreover, Hospital witnesses made clear that they did not join in enforcing the direct billing ban because of any provision in their 50 year-old agreements defining the contours of covered Blue Cross hospital services. On the contrary, as one experienced hospital chief financial officer testified regarding the applicable contractual language:

> I don't quite understand number three under paragraph number five, hospital care, "the benefits hereunder do not include services to the [subscriber's] attending physicians, surgeons, special nurses and their board. Separate arrangements must be made with the physician and surgeon for the payment of his fee for professional services."
>
> My interpretation of that [provision] in 1988 is that . . . the radiologists have every right to bill for their services. (JA 505)

Indeed, in 1943, these hospital agreements had been amended to clarify that "hospital services" specifically *excluded* "physicians and surgeons' fees." (JA 714.3)* And respondent Empire's largest subscriber contract, covering a million New York state employees and their families, provides:

> *Hospital Services Covered:* Blue Cross will usually pay for all of the diagnostic and therapeutic services provided by the hospital. *However, the service must be*

* Likewise, Empire's standard 120-day hospital subscriber contract provides that "hospital benefits . . . do not include services charged for by a private practitioner." (JA 714.20)

> *given by an employee of the hospital, the hospital must bill for the service, and the hospital must retain the money collected for the service.* (Emphasis added) (JA 714.6-714.12)

Anomalously, if a subscriber under this statewide agreement is hospitalized in the upstate Albany area, Empire recognizes that professional services by a self-employed hospital-based radiologist are not "hospital services" and are to be direct billed. If the same subscriber, pursuant to the same subscriber agreement, receives care at one of the Downstate Hospitals, direct billing is banned.

But Empire decided, in April 1984, to ignore these contracts and the objections of the Hospitals. Acting solely to preserve its monopoly of the hospital insurance market and to leverage that market power to avoid further impairment of its weaker share in the more competitive medical insurance market, Empire imposed its "billing ban" and coerced the Hospitals to enforce it — even though the Hospitals had ceased paying compensation to the radiologists and permitted direct billing for all other classes of patients. And it did so knowing full well that it would inflict damages of approximating $25 million annually upon the radiologists. (JA 535-36, 555)

II. The proceedings below:

Petitioners are some 60 groups of physicians practicing their medical specialty of radiology at the Downstate Hospitals. They comprise nearly 500 physicians — the majority of the hospital-based radiologists in the Downstate geographic area.

Like other self-employed private physicians, they direct bill their private, Medicare and Medicaid patients on a fee-for-service basis. But unlike their hospital-based peers in other medical specialties, including the anesthesiologists, they are banned from billing patients who happen to be Blue Cross subscribers. And that ban is enforced by the Hospitals, as a result of coersion by Empire.

In April of 1985, petitioners filed this suit in the Southern District of New York, alleging violations of Sections 1 and 2 of the Sherman Act. They charged that Empire conspires with the

Hospitals to tamper with the price mechanism for their radiological services, attempts to monopolize the hospital insurance market by suppressing their right to direct bill, and leverages its hospital insurance monopoly to shore up its weak Blue Shield affiliate in the medical insurance market.

Empire moved to dismiss, principally in reliance upon the First Circuit's decision in *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). Empire argued that *Kartell* stands for the sweeping proposition that a buyer has an absolute right to determine what it wants to buy — in this case a bundle of hospital services which includes radiological services — and no antitrust issue arises when it finds a "willing" seller — here, the Hospitals.

A. The original district judge rejects Empire's argument

The federal district judge to whom this case was initially assigned rejected Empire's position in an opinion reported at 659 F. Supp. 132 (S.D.N.Y. 1987). (A-26 through A-36) The judge observed that a careful reading of *Kartell* disclosed no such right, for the First Circuit had confined its ruling to a purely bilateral situation between "legitimate" buyers and sellers of the services in question.[5] As the court put it,

> [I]f the insurance plan in *Kartell* had not dealt bilaterally with the physician-sellers of medical services but instead had acted as an inhibitory "third force" interfering in a separate buyer/seller relationship involving other persons, the relationship would not have been exempt from antitrust scrutiny.

---

[5] The First Circuit had, after all, emphasized that "Here, Blue Shield and the doctors sit on opposite sides of the bargaining table.' " 749 F.2d at 929. And it had explained, at 924, that "To find an unlawful restraint, one would have to look at Blue Shield as if it were a third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains."

659 F. Supp. at 135-36. (A-32)[6]

B. A newly assigned district judge accepts the same arguments her judicial predecessor had rejected, granting summary judgment in favor of respondent

At the conclusion of over three years of discovery, Empire moved for summary judgment. At this point, the case was reassigned to a newly appointed district judge, the Hon. Kimba M. Wood. On February 24, 1989, the new judge abruptly granted summary judgment for Empire, accepting both the same legal grounds her judicial predecessor had rejected and Empire's characterization of the disputed facts.

Judge Wood read *Kartell* as standing for the expansive rule that a buyer — even one with unquestioned monopoly power — has an unfettered right to decide what combination of goods and services it wants to buy, and no antitrust objection can be made if it uses that monopoly power to coerce an unwilling "seller" to sell such a package. She rejected as without meaning Empire's anti-competitive motives, its monopoly power in the hospital insurance market, and its coercion of the Hospitals to join in enforcing the direct billing ban.

Empire's own admissions and the sworn testimony of its senior management and hospital officials abundantly supported the contrary conclusion that it had set out unlawfully to enhance its monopoly in one market and weak affiliate in a second, that it used its "hospital contracts" as a cover to impose terms contradicted by those same contracts, and that it embroiled the unwilling Hospitals in its scheme through coercive use of its monopoly power.

---

[6] The court also rejected respondent's Section 2 standing argument, finding that petitioners' "injuries are the 'precisely intended' consequence of Empire's alleged antitrust violations and are 'inextricably intertwined' with the advantages sought against its competitors." 659 F. Supp. at 137 (A-35), citing *Crimpers Promotions, Inc. v. Home Box Office, Inc.*, 724 F.2d 290 (2nd Cir. 1983).

But Judge Wood chose to ignore or belittle these facts. Instead, she elected to characterize Empire as though it were the "legitimate buyer" postulated by *Kartell*, with the unfettered right to obtain its desired package of services from "willing sellers," the Downstate Hospitals.

C. The Court of Appeals affirms

On September 14, 1989, the Court of Appeals for the Second Circuit affirmed on the opinion below. (A-3 to A-4)

REASONS FOR GRANTING THE WRIT

With 9 million subscribers in a market of only 11 million people, and control of $1 billion in Blue Cross payments and another $1.6 billion in federal Medicare payments, Empire has enormous market power. Uncontroverted evidence shows that it uses that power to coerce the Downstate Hospitals, against their own self interest, to enforce the challenged "billing ban." And it does so for anti-competitive purposes and at the expense of the radiologists.

An increasingly sensitive issue in antitrust law today concerns the limitations, if any, upon the use and abuse of this kind of power. What restraints are there, if any, upon the sheer power of a monopolist or monopsonist to entrench itself or stomp out incipient threats to its position? Can such dominant forces insulate themselves from effective antitrust scrutiny behind some "unfettered right" of a "buyer" to choose with whom to do business, to decide what combination of goods and services it wants to buy and at what price, and to get its way by resort to coercion? And even if there are limitations, are they to be waived so long as the monopolist trots out the banner of alleged "cost containment" to paper over its admitted pursuit of still greater market share?

The decisions below liberate the dominant market force from the restraints which have been developed by this Court, expand the controversial *Kartell* decision and its progeny beyond the purely "bilateral" context in which they were decided, and substitute

a judge's pretrial factual conclusions as to how to characterize such behavior for the contrary conclusions a jury would have been entitled to reach.

I. The decision below conflicts with and erodes this Court's decisions in *Aspen Skiing* and *Lorain Journal*, which impose essential limitations on misuse of market power

Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585 (1985), and *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), stand for the proposition that monopolists have no unfettered right like the one sanctioned by the decisions below. In both cases, dominant market forces set out to protect their market share. When challenged, they defended on the ground that all they had done was to make entirely lawful "unilateral" decisions about those with whom they would do business. This Court did not sustain such an unfettered right.

In *Aspen Skiing*, for example, the monopolist ski area was held to have violated Section 2 when it chose to discontinue participation in a ski-lift ticket program interchangeable in all four of Aspen's ski areas, with the intent and effect of improving its already dominant position *vis a vis* the smaller ski areas. And in *Lorain Journal*, the monopolist was found to have violated Section 2 when it simply and unilaterally refused to sell advertising to anyone who patronized a small nearby radio station which dared to compete.

In short, the pious truism articulated below that a "buyer" has an absolute right to define for itself what it wants to buy, what price it will pay, and how it will pursue its objectives has limitations – at least where, as here, monopoly power is involved. As the *Lorain* court said, in language quoted and reaffirmed in *Aspen Skiing:*

> The publisher claims a right as a private business concern to select its customers and to refuse to accept advertisements from whomever it pleases. We do not dispute that general right. "But the word 'right' is one

> of the most deceptive of pitfalls; it is so easy to slip from a qualified meaning in the premise to an unqualified one in the conclusion. Most rights are qualified. . . ." The right claimed by the publisher is neither absolute nor exempt from regulation. Its exercise as a purposeful means of monopolizing interstate commerce is prohibited by the Sherman Act.

472 U.S. at 601-02, quoting from 342 U.S. at 155.

The decisions below seriously erode these limitations. For they permit the monopolist's asserted "right" to evade antitrust scrutiny so long as it comes wrapped up in a "package" of goods and services the monopolist wants to "buy" and which it is able to coerce from an unwilling "seller" — even if the latter does not ordinarily "sell" what the monopolist insists on "buying."

Given the economic power of organizations like Empire, and the clout they exercise over the Nation's hard-pressed hospitals — and which the decisions below license them to extend to self-employed physicians — review is essential. Otherwise, the Downstate New York "exception" to the universal rule that self-employed physicians direct bill their own patients will surely spread to other jurisdictions — and one more area of economic freedom will drown in a sea of monopoly power. And restraints heretofore thought to limit the power of monopolists generally under decisions like *Lorain Journal* and *Aspen Skiing* will have been seriously eroded.

Because the courts below were beguiled by the notion of a "buyer's unfettered right," they disregarded the relevance of any particular limits on that power. One factor pushing them in that direction was Empire's *post hoc* rationalization about alleged "cost containment." But such reliance upon "cost containment" — a concern belied by Empire's contemporaneous anxiety about "imperil[ing] market share" — is foreclosed by this Court's landmark decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), invalidating a "maximum fee" schedule adopted by local medical societies. This Court found such medical services

industry "cost containment" a *per se* violation of the antitrust laws because it involved tampering with price. As the Court wrote:

> Any combination which tampers with price structures is engaged in an unlawful activity. . . . [T]o the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces. The [Sherman] Act places all such schemes beyond the pale and protects that vital part of our economy against any degree of interference. Congress has not left with us the determination of whether or not particular price-fixing schemes are wise or unwise, healthy or destructive.

457 U.S. at 346, quoting *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221-22 (1940). Furthermore, this Court expressly rejected the suggestion that on "public policy" grounds health care and the medical profession should be exempted from the prohibition against tampering with price or price structure.

Review by this Court is required to prevent such use of the "cost containment" excuse to shield price-related misconduct by those possessing monopoly power.

II. The decision below conflicts with the First Circuit's *Kartell* decision, and dangerously expands the license afforded purchasers with monopoly power

Although Judge Wood purported to rely on the First Circuit's *Kartell* decision, she declined to recognize its self-expressed limitations. As affirmed, her decision is both in conflict with *Kartell* and expands it far beyond its intended scope. In consequence, it dangerously expands the license afforded those who would abuse monopoly power.

Judge Wood's judicial predecessor, Judge Shirley Wohl Kram, understood that when, at the outset of this litigation, she distinguished *Kartell* in denying respondent Empire's initial motion.

As she observed, 659 F. Supp. 132, at 135-36, *Kartell* involved a dispute between the two opposing sides to an actual agreement. Defendant Blue Shield[7] had routinely negotiated with the same groups of physicians who were now plaintiffs – and who were challenging agreements they had themselves reluctantly made with Blue Shield. After a full trial, the First Circuit concluded that it would hold the parties to their own bargain – and that *purely bilateral* negotiations between *legitimate* buyers and sellers over the terms under which the sellers would provide their own personal services do not give rise to antitrust claims.

The First Circuit had taken care to distinguish the situation where the arrangement at issue is not "bilateral" but involved intervention between buyer and seller by some outside "third force" nor normally party to their negotiations.[8] In that situation – which ours presents – the result would be entirely different. As Judge Breyer put it,

> To find an unlawful restraint, one would have to look at [defendant] as if it were a "third force," intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains.

749 F.2d at 924.

Judge Breyer's distinction between bilateral and trilateral conduct is consistent with basic antitrust doctrine. Judge Wood sought to brush off the difference by arguing that

---

[7] Note that the defendant in *Kartell* was not hospital insurer Blue Cross, but Blue Shield – the medical insurer which pays physicians' bills, which routinely negotiates fee schedules with private physicians, and which had negotiated with them the agreements they challenged.

[8] Except for the decision below, *Kartell*'s numerous progeny honor this intrinsic limitation now discarded in the Second Circuit. See, e.g., *Barry v. Blue Cross of California*, 805 F.2d 866 (9th Cir. 1986); *Ball Memorial Hosp. v. Mutual Insurance*, 784 F.2d 1325 (7th Cir. 1986); and *Sausalito Pharmacy v. Blue Shield of California*, 544 F. Supp. 230 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982).

> Hence, if Blue Cross had chosen to purchase radiology services directly from the Radiologists, case law would clearly suport their right to do so and to ban balance billing to patients. (A-13)

But is it no defense to a Section 1 claim directed at concerted activity that the same result could be lawful had it been done unilaterally. In *United States v. General Motors Corp.*, 384 U.S. 127 (1966), the Government sued to stop General Motors from conspiring with dealers to terminate other dealers who provided cars to discounters. Defendant relied on the "location clause" in its dealer franchise agreement, contending that this clause would have entitled it to proceed on a unilateral basis. This Court rejected that argument, noting:

> Whatever General Motors might or might not lawfully have done to enforce [the agreement] is beside the point. And, because the action taken constitutes a combination or conspiracy, it is not necessary to consider what might be the legitimate interest of a dealer in securing compliance by others with the "location clause," or the lawfulness of action a dealer might individualy take to vindicate this interest.

384 U.S. at 140.

The decisions below, as affirmed by the Court of Appeals, write these careful and essential limitations out of *Kartell*. Contrary to *Kartell*, it is now the rule in the Second Circuit that it matters not whether the situation is bilateral or trilateral, whether plaintiff was himself party to the "bargain" he wishes to challenge, or whether the alleged "buyer" or "seller" are legitimately buyers and sellers of the goods or service at issue. Moreover, in the Second Circuit (and wherever else its expansion of *Kartell* may be followed) it matters not that the putative "buyer" abuses its market power to coerce a "sale" from an unwilling "seller."

Judicial condonation of this kind of license unleashes those most in need of restraint. Given the importance of this issue and its recurrent nature, this Court ought to eliminate the conflict and

clarify the rules governing abuse of market power in the guise of exercising one's "unfettered right" to "buy."

III. The decision below departs from sound summary judgment practice, and in this respect also conflicts with and erodes *Aspen Skiing* and *Lorain Journal*

If anything is clear, it is that Judge Wood would never have permitted *Aspen Skiing* to go to the jury, for in her view she was entitled, on summary judgment, herself to determine how to "characterize" what defendant was doing.

Defendant's own formal board minutes, the deposition testimony of its own senior management, the uncontroverted deposition testimony of Downstate Hospital executives, and the inferences permissibly drawn from these materials would permit — if not compel — a fact-finder to accept petitioners' view of Empire's misconduct.

Although Judge Wood had an obligation, even after *Matsushita Electric Ind. Co. v. Zenith Radio Corp*, 475 U.S. 574 (1986), to accept the facts supporting petitioners' position and to draw all inferences in their favor, she did precisely the opposite. Setting aside or ignoring the well-developed facts about Empire's motive, intent, and coercive tactics,[9] she chose to decide for herself the ultimate fact issue — whether Empire was a "monopoly power" abuser like the *Aspen Skiing* and *Lorain Journal* defendants, or on the other hand, the benign innocent "buyer" coupled with a happily complaisant "seller" as postulated in *Kartell*.

---

[9] The district court's reaction to the factual contentions raised on summary judgment is illustrated by her conclusion, at A-17, that weight should be given to the fact that "the Blue Cross purchasing system attacked here is supervised by state regulators." Yet she had before her the affidavit of the New York State Insurance Superintendent who swore that "Empire's decision to include the plaintiffs' services within its Blue Cross plan is not mandated by any state law, rule or regulation." (JA 634). And senior Empire officials had testified that they knew of no state law, rule or regulation requiring Empire to impose its ban on direct billing by the radiologists. (JA 527-28)

Such issues of "characterization," which inescapably involve questions of motive and intent, are not to be decided on summary judgment, except where all the facts favor the motion, or the opposition to the motion is "implausible." *Matsushita*, 475 U.S. at 593.[10] Indeed, if anything was "implausible," it was the "bilateral willing buyer and seller" scenario insisted upon by the district court despite all evidence to the contrary.

The teaching of *Poller v. Columbia Broadcasting System*, 368 U.S. 464 (1962), remains valid:

> [S]ummary procedures should be used sparingly in complex antitrust litigation where motive and intent play leading roles, the proof is largely in the hands of the alleged conspirators, and hostile witnesses thicken the plot.

368 U.S. at 473. This is especially so in "rule of reason" cases where, as pointed out in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978),

> competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed.

The facts developed after three years of discovery, if proven at trial, may have permitted a jury to reach the same conclusion as did Judge Wood regarding the proper characterization of Empire and its conduct. Surely, those same facts would even more easily have permitted the jury to place Empire in the same category as the *Aspen Skiing* and *Lorain Journal* defendants — as abusers of monopoly power. Or as an "intervening third force"

---

[10] Another example of Judge Wood's failure to recognize the proper limits of her role is demonstrated by her bald conclusion that petitioners had offered no evidence to demonstrate any anti-competitive impact. (A-15) Her conclusion totally ignored affidavits from senior hospital officials who testified that certain of Empire's competitors sought to purchase the same package of services from the hospitals, but were refused since they lacked the market clout to induce the hospitals to disregard their own self-interest. (JA 1077-90).

within the meaning of *Kartell*. On summary judgment, the court had no right to choose between those conflicting sets of factual conclusions — and select the one sponsored by the party seeking summary judgment.

If district judges are free to disregard massive evidence of anti-competitive intent, and of the kind of "unduly coercive conduct" about which Judge Learned Hand warned in *United States v. Aluminum Company of America*, 148 F.2d 416, 429 (2nd Cir. 1945), and conjure up out of whole cloth the "benign, purely bilateral willing buyer and seller" scenario imagined below, then a gaping hole will have been cut in the federal laws regulating anti-competitive behavior.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the decision and judgment of the Court of Appeals for the Second Circuit, as well as the underlying decision granting summary judgment in favor of Empire's coerced ban on direct billing.

December 12, 1989

Respectfully submitted,

GARFUNKEL, WILD & TRAVIS, P.C.
NORTON L. TRAVIS
(Counsel of Record)
175 Great Neck Road
Great Neck, New York 11021

REID & PRIEST
DANIEL P. LEVITT
40 West 57th Street
New York, New York 10019

Attorneys for Petitioners

APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE
SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the fourteenth day of September one thousand nine hundred and eighty-nine.

Present: HON. WILFRED FEINBERG,
HON. JON O. NEWMAN, Circuit Judges.
HON. EDWARD DUMBAULD,
District Judge.*

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,

Plaintiffs-Appellants,

—against— Docket No. 89-7305

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Defendant-Appellee.

Appeal from the United States District Court for the Southern District of New York

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York and was argued by counsel.

---

* Honorable Edward Dumbauld, Senior United States District Judge for the Western District of Pennsylvania, sitting by designation.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the order of said District Court be and it hereby is affirmed in accordance with the opinion of this court with costs to be taxed against the appellants.

Elaine B. Goldsmith,
Clerk

/s/Edward J. Guardaro
by: Edward J. Guardaro,
Deputy Clerk

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,
Plaintiffs-Appellants,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC., Defendant-Appellee.

No. 1349, Docket 89-7305.

United States Court of Appeals,
Second Circuit.

Argued Aug. 31, 1989.

Decided Sept. 14, 1989.

Appeal from order of the United States District Court for the Southern District of New York, Kimba M. Wood, J., holding that the arrangements between defendant-appellee Empire Blue Cross and Blue Shield, Inc. and downstate New York hospitals, whereby inpatient radiological services are purchased as part of a package of hospital services, did not violate sections 1 and 2 of the Sherman Act. 15 U.S.C. §§ 1, 2.

Affirmed.

Daniel P. Levitt, New York City, Reid & Priest (Norton L. Travis, Garfunkel, Wild & Travis, P.C., of counsel), for plaintiffs-appellants.

Robert A. Bicks, New York City, Breed, Abbott & Morgan (Howard S. Wolfson, of counsel), for defendant-appellee.

Vedder, Price, Kaufman & Kammholz, Chicago, Ill. (Paul G. Gebhard, William C. Glynn, of counsel), for American College of Radiology, amicus curiae.

Before FEINBERG and NEWMAN, Circuit Judges, and DUMBAULD, District Judge.*

---

* Honorable Edward Dumbauld, Senior United States District Judge for the Western District of Pennsylvania, sitting by designation.

PER CURIAM:

Plaintiffs-appellants, a majority of the hospital-based radiologists in 17 downstate counties in and around New York City, appeal from an order of the United States District Court for the Southern District of New York, Kimba M. Wood, J., granting the motion for summary judgment of defendant-appellee Empire Blue Cross and Blue Shield, Inc. ("Empire"). Appellants challenge the arrangements between Empire and the downstate hospitals, whereby inpatient radiological services are purchased as part of a package of hospital services, so that radiologists do not bill Blue Cross subscribers directly for their services. Appellants contend that Empire's arrangements with the hospitals violate section 1 of the Sherman Act, 15 U.S.C. § 1, by coercing the hospitals, through the use of monopoly power, to sell the services of appellants radiologists on terms that Empire could not obtain through legitimate bilateral negotiations with appellants. Appellants further contend that Blue Cross insists on so purchasing inpatient radiological services in order to use its leverage in the hospital insurance market to gain a competitive advantage in the medical services insurance market in contravention of section 2 of the Sherman Act. 15 U.S.C. § 2. Appellants finally argue that the court below should not have granted summary judgment because there were issues of fact for a jury.

We affirm for the reasons stated in Judge Wood's well-reasoned opinion, reported at 707 F.Supp. 708.

----------X

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., ET AL.,

Plaintiffs,

— against —

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Defendant.

: 85 CIVIL 2733 KMW

: JUDGMENT

----------X

Defendant having moved for summary judgment and the plaintiffs having cross-moved for partial summary judgment to strike the McCarran-Ferguson and state action defenses, and the said motions having come before the Honorable Kimba M. Wood, U.S.D.J. and the Court thereafter on February 27, 1989, having handed down its opinion and order (#63857), granting defendant's motion for summary judgment and dismissing this action with prejudice, it is,

ORDERED, ADJUDGED AND DECREED: That this action be and it is hereby dismissed with prejudice.

DATED: NEW YORK, N.Y.
February 28, 1989

/s/Raymond F. Burghardt
Clerk

THIS DOCUMENT WAS ENTERED ON THE DOCKET ON 3-1-89.

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,
Plaintiffs,

v.

EMPIRE BLUE CROSS AND BLUE
SHIELD, INC. Defendant.

No. 85 CIV. 2733 (KMW).

United States District Court,
S.D. New York.

February 24, 1989.

Hospital-based radiologists brought action against health insurer alleging unlawful restraint of trade, monopolization and price fixing in violation of federal antitrust laws on ground that insurer insisted that hospitals that contracted to offer radiological services to insurer's subscribers do so at a certain price as part of a package of such services. On defendant's motion for summary judgment, the District Court, Kimba M. Wood, J., held that: (1) health insurer's agreement with hospitals did not constitute illegal price fixing, as there was no evidence of any injury to competition flowing from agreement, and (2) even assuming that insurer used its market power to obtain favorable prices from hospitals for provision of radiological services, antitrust laws did not prevent buyer with market power from negotiating good price or specifying what it will buy when there was no evidence of injury to insurer's competitors.

Motion granted.

OPINION AND ORDER

KIMBA M. WOOD, District Judge.

Plaintiffs allege unlawful restraint of trade, monopolization, and price fixing in violation of the federal antitrust laws and New York State law. 15 U.S.C. §§ 1, 2; N.Y.Gen.Bus.Corp.Law § 340. Plaintiffs seek treble damages and injunctive relief. The case is presently before the Court on defendant's motion for summary judgment on the grounds that (1) defendant's alleged conduct does not violate Sections 1 and 2 of the Sherman Act; (2) plaintiffs' claims are barred by the McCarran-Ferguson Act; and (3) plaintiffs' claims are barred by the state action doctrine. Plaintiffs cross-move for partial summary judgment to strike the McCarran-Ferguson and state action defenses.

In proceedings before the judge to whom this action was originally assigned, defendant moved to dismiss the complaint. Although the Court believes that defendant's prior motion should have been granted, the Court has considered all the affidavits, exhibits, and legal memoranda submitted by the parties. After a thorough review of the record, the Court finds that there is no genuine issue as to any material fact and that defendant is entitled to judgment as a matter of law. Accordingly, defendant's motion is hereby granted and plaintifffs' cross-motion is denied.

FACTS

The key facts are not in dispute. Plaintiffs are a majority of the hospital-based radiologists (the "Radiologists") who work in the 17 counties in and around New York City ("Downstate New York").[1] Defendant Empire Blue Cross and Blue Shield, Inc.

---

[1] Radiologists are licensed physicians who have completed special residency programs in radiology and have thereby become qualified in that particular medical specialty. The Second Amended Complaint defines radiology as "the medical specialty concerned with the diagnostic and therapeutic use of X-rays, radium rays and other forms of radiant energy or its equivalent, in the diagnosis and treatment of disease or injury." Second Amended Complaint, ¶ 5. The radiology services that plaintiffs seek to exclude from coverage in Blue Cross' hospital coverage contracts are non-interventional (*i.e.*, non-surgical) inpatient diagnostic and therapeutic radiological services. For ease of reference, these will be referred to simply as "radiology services."

("Empire") is a non-profit health insurance corporation organized and existing under Article 43 of the New York Insurance Law. Empire is the product of a merger of Blue Cross/Blue Shield of Greater New York, Inc., which served Downstate New York, and Blue Cross of Northeastern New York, Inc., which served the Northeastern New York area.

Empire offers two basic insurance plans: "Blue Cross," which covers certain defined hospital services and benefits, and "Blue Shield," which covers certain professional medical services provided by physicians. An individual or group may purchase one plan without purchasing the other; that is, one may purchase both Blue Cross coverage and Blue Shield coverage, Blue Cross coverage without Blue Shield coverage or Blue Shield coverage without Blue Cross coverage. Empire provides Blue Cross hospital service benefit coverage to more than 9 million covered persons. Some of these individuals buy partial hospital benefit coverage from Blue Cross, and supplemental hospital benefit coverage from others.

In order to provide inpatient hospital services pursuant to these subscriber contracts, Blue Cross entered into contracts with hospitals whereby the hospitals accept payments from Blue Cross as full reimbursement for covered services rendered to Blue Cross subscribers (*i.e.*, the hospitals may not seek to collect additional charges from Blue Cross' subscribers). Since Blue Cross' founding over 50 years ago, the Downstate New York hospitals have provided technical (and, as they developed, professional) radiology services to Blue Cross subscribers as covered hospital services. See Defendant's Rule 3(g) Statement, ¶ 7; Supplement to Plaintiffs' Rule 3(g) Statement, ¶ 7.

Radiology services were usually provided by hospital employees until the 1970's. In the 1970's, as radiology developed as a specialty, many radiologists chose to become independent contractors to hospitals rather than to be hospital employees, although they continued to practice on the hospital premises. At the same time, the Radiologists began to seek to bill Blue Cross subscribers directly on a fee for service basis rather than to bill the hospitals, which in turn bill Blue Cross. In most areas

Blue Cross has acquiesced, and no longer requires hospitals to offer radiology services as part of a package of hospital services. In those areas, Radiologists either bill patients directly or bill their medical insurance plans.

In the 17 downstate counties in New York, however, Blue Cross insists that hospitals that contract with Blue Cross continue to offer radiology services to Blue Cross subscribers as part of a package of hospital services. The Radiologists claim that this practice has the effect of "unnaturally" limiting how much they can charge for their services. That is, they could charge patients more if they could bill patients directly, by-passing both hospitals (whose charges are closely monitored by a number of regulatory agencies, state and federal) and Blue Cross (whose purchasing power permits it to drive a hard bargain).[2] The Radiologists also point out that they feel demeaned by their inability to bill in the same manner permitted to other physicians. Second Amended Complaint, ¶ 29. Recognizing, as they must, that the antitrust laws provide no remedy either for being professionally demeaned or for not being able to charge as much as one would like, the Radiologists attempt to bring their claim within the ambit of the antitrust laws in two ways.

First, the Radiologists claim that the agreement between Blue Cross and each hospital results in price fixing which unreasonably restrains trade, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Second, they claim that Blue Cross' ability to extract favorable terms from hospitals results from Blue Cross' enormous purchasing power, and that Blue Cross is (1) using its purchasing power to monopolize the hospital service and benefit insurance market, and (2) leveraging its power in the hospital service and benefit insurance market to give a competitive advantage to its affiliate, Blue Shield, in the medical service market – all to the alleged detriment of other insurers and health maintenance organizations, all in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

---

[2] According to Radiologists, they could bill $25 million more per year in Downstate New York if they could bill patients directly.

DISCUSSION

1. Sherman Act § 1

[1] Recent Supreme Court decisions suggest that a court should begin its antitrust analysis with a threshold examination of an alleged restraint.[3] If the alleged restraint appears clearly anticompetitive, a court should find the restraint to be *per se* unlawful; if the alleged restraint may be necessary to achieve a pro-competitive result, a court should test the restraint by the rule of reason. The restraint here is not clearly anticompetitive, and may be necessary to achieve a pro-competitive result. Blue Cross produces lower prices for consumers by using its bargaining power to purchase radiology services as part of a bundle of hospital services. The challenged agreements are ancillary to Blue Cross' attempt to design efficient insurance coverage for subscribers, and may counter what has been characterized by several commentators as a historical insensitivity of physician prices to competition. *See* "Joint Provider Activities Affecting Price," ABA Antitrust Section Draft Working Paper 4-10, 73-75 (1989); Note, *Prepaid Prescription Drug Plans Under Antitrust Scrutiny: A Stern Challenge to Health Care Cost Containment*, 75 Nw.U.L.Rev. 506, 518 n. 69, 524-525; D.W. Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 647-649 (1978); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross and Blue Shield of Connecticut, Inc.*, 675 F.2d 502, 506 (2d Cir.1982) (reference to "the normal insensitivity of drug prices"). The agreements permit a sophisticated buyer, Blue Cross, to monitor and predict charges, and permit it to offer cost containment as a service to its less sophisticated, individual subscribers.[4] *See Prepaid*

---

[3] *NCAA v. Board of Regents*, 468 U.S. 85, 107, 104 S.Ct. 2948, 2963, 82 L.Ed.2d 70 (1984); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982); *Broadcast Music Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 99 S.Ct. 1551, 60 L.Ed. 2d 1 (1979); 7 P. Areeda, Antitrust Law ¶ 1511, at 431 (1986).

[4] Kallstrom wrote, eleven years ago:
Given the chance to run their natural courses, market incentives should draw insurance companies into the business of offering cost containment as a

(Footnote continued)

Prescription Drug Plans, *supra*, at 524; *Kallstrom*, *supra*, at 649. In 1982 the Second Circuit held that similar conduct was properly analyzed under the rule of reason. The Court held that in determining whether a restraint is unreasonable, a court must analyze

> whether, under all of the circumstances of the case, including the facts peculiar to the business and the history of, reasons for, and market impact of the restraint, the restrictive practice imposes an unreasonable restraint on competition.

Medical Arts, 675 F.2d at 504.

The Radiologists claim that the agreements between hospitals and Blue Cross restrain competition in violation of Sherman Act Section 1 by preventing the Radiologists from billing directly patients who are Blue Cross subscribers.[5] This claim is similar to ones asserted over the past fifteen years by other providers of goods and services to insurers. Health care providers, in particular, dismayed by the diminution of their market power vis-a-vis buyers representing large numbers of patients, have recently attempted numerous antitrust attacks upon insurers. Courts have consistently rejected, in the health insurance context, the argument advanced in many of these attacks that the antitrust laws

---

service to health care consumers. That insurance companies have not already undertaken to provide this service indicates that market forces have not been permitted to operate freely. At every turn in the road to cost-control innovation insurers have been faced with barriers, often in the form of restrictive practices of organized medicine or of legislation created at the behest of the medical establishment. [Footnote omitted.] *Kallstrom*, *supra*, at 649.

[5] Two other arguments made by the Radiologists in connection with their Section 1 claim have no basis in antitrust, and a third will be assumed by the Court to be correct for purposes of this motion. The argument that Blue Cross and hospitals "are not legitimately concerned with physicians' fees" has no basis in antitrust, unless it is an attack on Blue Cross' ban on direct billing, dealt with *infra*, pp. 711-13. Similarly, there is no antitrust basis for the argument that it is unreasonable for Blue Cross to buy radiology services from hospitals, given that Blue Cross chooses to buy no other physicians' services

(Footnote continued)

give providers of goods and services a right to bill directly patients who are Blue Cross or Blue Shield subscribers. Doctors and pharmacies, among others, have sued health insurers for refusing to let them bill patients directly amounts *in addition* to those the doctors and pharmacies receive from the insurers. Courts have consistently held that this "ban on balance billing" does not unreasonably restrain trade; the only restraint is the one that flows inevitably and properly from the choice by the insurer to buy services and products of a particular type from doctors and pharmacies, *i.e.*, fully-paid services and products.[6] *Medical Arts*, 675 F.2d 502 (Blue Shield may require pharmacies to accept Blue Shield payments as full reimbursement for drugs sold to Blue Shield subscribers); *Kartell v. Blue Cross of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir.1984)(Blue Shield may

---

from hospitals; nothing in the antitrust laws requires buyers to be consistent. The Radiologists also argue that it is contrary the hospitals' self interest to sell radiology services, given the additional administrative burden that entails; this argument is presumably made in support of the Radiologists' contention that Blue Cross has market power. The Court accepts as true, for purposes of this decision, the contention that Blue Cross has market power. *See* pp. 714-15 *infra*.

[6] It is difficult to tell from the Radiologists' submissions to the Court whether the Radiologists argue that Blue Cross should not be characterized as a "buyer" because it buys on behalf of subscribers. That argument would be unavailing. For antitrust purposes, Blue Cross is treated as a buyer where it pays the bill and seeks to set the amount to be charged. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 216, 217, 99 S.Ct. 1067, 1075-1076, 59 L.Ed.2d 261 (1979); *Medical Arts*, 675 F.2d at 505; *Kartell, et. al. v. Blue Shield of Massachusetts, Inc., et al.*, 749 F.2d 922, 925, 928 (1st Cir.1984), *cert. denied* 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322 (1985); *Brillhart v. Mutual Medical Ins. Inc.*, 768 F.2d 196, 199 (7th Cir. 1985); *Michigan State Podiatry Ass'n v. Blue Cross and Blue Shield of Michigan*, 671 F.Supp. 1139, 1152 (E.D.Mich.1987); *Mortensen v. First Federal Savings and Loan Ass'n*, 1975-2 Trade Cas. (CCH) ¶ 60,570 at 67,501 (D.N.J.1975), [1975 WL 972]; *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F.Supp. 230, 233, 238 (N.D.Cal.1981), *aff'd.* 677 F.2d 47 (9th Cir.1982), *cert. denied*, 459 U.S. 1016, 103 S.Ct. 376, 74 L.Ed.2d 510 (1982); *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 784 F.2d 1325 (7th Cir.1986); *Pennsylvania Dental Assoc. v. Medical Service Assoc.*, 815 F.2d 270 (3d Cir.), *cert. denied*, __U.S.__, 108 S.Ct. 153, 98 L.Ed.2d 109 (1987); *Blue Cross and Blue Shield of Michigan v. Michigan Assoc. of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich.1980)[1980 WL 1848].

require doctors to accept Blue Shield payments as full reimbursement for services sold to Blue Shield subscribers; *i.e.*, Blue Shield may ban balance billing); *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed.2d 550 (1973)(Blue Cross may require hospitals to accept Blue Cross payments as full reimbursement for services rendered to Blue Cross subscribers); *see Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195 (7th Cir.1981), *cert. denied*, 455 U.S. 1020, 102 S.Ct. 1717, 72 L.Ed.2d 138 (1982)(auto insurers may require repair shops to accept payment at the "prevailing competitive rate" as full reimbursement for their services). Hence, if Blue Cross had chosen to purchase radiology services directly from the Radiologists, case law would clearly support their right to do so and to ban balance billing to patients.

The only distinctions between the above-cited cases and the instant case are distinctions with no antitrust significance. First, the Radiologists seek to bill patients for their entire fee, rather than the balance over the amount paid by an insurer. The decisions cited above, however, stand for the proposition that the antitrust laws do not prohibit a buyer either from buying for the account of others, or from specifying that the services it buys be fully-paid services. The Radiologists do not have to serve Blue Cross subscribers; if they do so, however, they must accept the payment in conditions specified by Blue Cross, that is, all payments must come from Blue Cross, not from the subscribers.

Second, here there is one more intermediary interposed between the physician and the patient, *i.e.*, the hospital.[7] It is difficult to see why this fact should have any antitrust significance. The Radiologists' argument is as follows: Blue Cross insists that hospitals sell it fully paid hospital services, including radiology

---

[7] The only detriment to the Radiologists that is added by the hospital being an intermediary between the Radiologists and Blue Cross is that hospital costs are subject to governmental regulation that may have the effect of containing costs. *See* Affidavit of James Corcoran, Esq., New York State Superintendent of Insurance, July 12, 1988 (hereinafter "Corcoran Aff."), ¶ 31. This fact has no bearing on the analysis above.

services; to effect the sale, hospitals must, in their agreements with the Radiologists, forbid the Radiologists to bill patients directly for services sold to Blue Cross through the hospitals; Blue Cross has thereby intervened as a "third force" in the relationship between the hospitals and the Radiologists; the First Circuit's recent *Kartell* decision states (in *dictum*) that it would be unlawful for a "third force" to "prevent willing buyers and sellers from independently coming together to strike price/quality bargains." *Kartell*, 749 F.2d at 924.[8] Although *Kartell* contains what this Court reads as a jocular reference to a sinister "third force,"[9] there is no authority whatever for the proposition that a seller has an *antitrust* remedy where a buyer insists upon buying his services through an intermediary. This is not a case where Blue Cross is preventing willing buyers and sellers from independently striking bargains – the Radiologists and the hospitals are free to strike any bargains they wish with one another. But if they wish to sell to Blue Cross, they must sell

---

[8] Blue Cross raised this argument previously in its motion to dismiss. At that time, the judge to whom the case was then assigned denied the motion to dismiss, holding that the contracts between Blue Cross and the hospitals in this case are epxressly excluded from the holding in *Kartell* because Blue Cross was alleged to be a "third force" intervening in the relationship between the Radiologists and the hospitals. *Westchester Radiological Assoc., P.C. v Empire Blue Cross and Blue Shield, Inc.*, 659 F.Supp. 132 (S.D.N.Y.1987). For the reasons stated in this opinion, I believe that decision was erroneous and contrary to well-established antitrust precedent.

The Radiologists argue that the earlier decision constitutes law of the case and should not be disturbed. However, the law of the case doctrine "merely expresses the practice of courts generally to refuse to reopen what has been decided, not a limit to their power." *Messinger v. Anderson*, 225 U.S. 436, 444, 32 S.Ct. 739, 740, 56 L.Ed. 1152 (1912) (Holmes, J.). Furthermore, denial of a motion for summary judgment does not preclude the grant of summary judgment by another judge. *Wright v. Cayan*, 817 F.2d 999, 1002 n. 3 (2d Cir.1987), *cert. denied*, __U.S.__, 108 S.Ct. 157, 98 L.Ed.2d 112 (1987); *Dictograph Products Co. v. Sonotone Corp.*, 230 F.2d 131, 134-136 (2d Cir. 1956)(Hand, J.); Wright, Miller & Cooper, Federal Practice and Procedure § 4478 (1981).

[9] Counsel for the Radiologists are unaware of any case holding that an insurer acted as a "third force" under *Kartell*. Transcript of Oral Argument, January 5, 1989 (hereinafter "Tr.") at 24-25.

Blue Cross the package it wants to buy, and they must agree that the price charged to Blue Cross will be the only charge for the services.

Furthermore, the Radiologists have produced no evidence of any injury to competition flowing from this agreement. When questioned at oral argument, the Radiologists' counsel stated that "[t]he injury to competition is the competition between the defendant and its hospital insurance competitors, and Blue Shield and its medical insurance competitors." Tr. at 3-4. However, at oral argument the Radiologists' counsel admitted that the Radiologists have (1) no evidence that Blue Cross has done anything to prevent its competitors from negotiating with hospitals to buy the same bundle of services that Blue Cross buys (Tr. at 8),[10] (2) no evidence that Blue Cross has attempted to control agreements between the hospitals and other insurers (Tr. at 9-10), (3) no evidence that Blue Cross interferes in any way with the relationship between the radiologists and patients who are not covered by Blue Cross (Tr. at 10-12),[11] and (4) no evidence that Blue Cross direclty tells, or even suggests to, the hospitals

---

[10] The Radiologists cited no evidence in their papers or at oral argument that any of Blue Cross' competitors asked to buy from any hospital the same bundle of services that Blue Cross buys. (Tr. at 6-7). Subsequent to oral argument, the Radiologists submitted the affidavits of a vice president at each of two hospitals (Affidavit of James Pierce, January 23, 1989; Affidavit of Sylvia Hotlzberg, January 24, 1989). James Pierce attests that three health organizations sought the same terms as Blue Cross, and his hospital refused. Sylvia Holtzberg attests that one organization asked her hospital to include the services of hospital-based physicians within the services provided to subscribers, and was refused. Neither affidavit explains why the hospitals refused, and neither affidavit claims that Blue Cross was in any way involved in the hospitals' decision.

[11] The Radiologists concede that when a hospital-based radiologist treats a patient who is *not* a Blue Cross subscriber, Blue Cross' contracts with the hospitals have *no impact* on the radiologist's ability to direct-bill that patient. Plaintiffs' Memorandum of Law in Opposition, p. 12. It is only when a hospital-based radiologist provides services to a Blue Cross subscriber that the radiologist is forbidden to direct-bill patients.

what to pay radiologists (Tr. at 12-13).[12] The Radiologists' sole contention is that because of Blue Cross' market power, Blue Cross is able to get better terms for its subscribers than are other insurers. This is insufficient to make out a Section 1 claim. Blue Cross is simply acting as a rational buyer attempting to get the best possible terms for its subscribers.[13]

Finally, as in the *Kartell* case, there are additional circumstances here that favor applying traditional antitrust principles, rather than stretching to create new causes of action.

First, the Blue Cross system under attack here promotes cost containment in an area in which the government has recognized the need for cost containment. There has been a growing governmental realization that traditional ways of paying for health care provided little or no incentive for efficiency and were inherently inflationary. According to the United States Department of Health, Eductation and Welfare, "[p]robably the principal factor contributing to inflation has been the predominant system of third party reimbursement based on what institutions spend and what physicians charge."[14] Recognizing the need for government action to promote cost containment, legislatures,

---

[12] Furthermore, although Blue Cross makes the decision to include or exclude radiology services in its Blue Cross coverage, the evidence is clear that Blue Cross does not unilaterally fix the price of the hospital services as the Radiologists claim; New York State sets the price. See pp. 714-15 *infra*.

[13] *See, Brillhart*, 768 F.2d at 201:

> The antitrust laws do not prohibit a buyer from bargaining for the best deal possible. As the district court noted, the conduct by Blue Shield in the present case is not the type of conduct that the antitrust laws were intended to prohibit. This conclusion is especially true where there is no suggestion that Blue Shield ever conspired with any other health care insurer to set prices, where nonparticipating doctors remain free to charge their patients whatever price that they choose, and where participating doctors remain free to charge non-Blue Shield subscribers whatever price they choose. In sum, the provider agreement in this case does not violate the antitrust laws.

[14] United States Department of Health, Education and Welfare, Forward Plan for Health: Fiscal Years 1978-82, at 34 (1976).

including Congress and the New York State legislature, have adopted prospective payment systems for hospitals. Pursuant to these systems, the appropriate amount of reimbursement to a hospital for certain patient care is determined *before* the care is rendered, giving hospitals a strong incentive to contain costs. Similarly, the executive branch has recognized the need for cost containment in the health care field. In 1982, the Department of Justice Antitrust Division gave a favorable Business Review Letter to 160 not-for-profit hospitals (which represented 80% of all such hospitals in Ohio) who wanted to increase their market power by banding together to purchase hospital products jointly. The Department of Justice noted with approval that this joint buying scheme might enable the group to obtain lower prices, resulting in further cost containment by hospitals.[15]

Second, the Blue Cross purchasing system attacked here is supervised by state regulators. Although that supervision may or may not rise to the level needed to invoke the state action exception to the antitrust laws,[16] there is no dispute that New York State sets the reimbursement rate that Blue Cross may pay to hopitals for patient care:

> Blue Cross rate setting methodology is required by law to be consistent with the Medicaid rate setting methodology prescribed by the state. This means that Blue Cross can pay hospitals neither more nor less than the rate established by state law, as determined by the [New York State] Department [of Health].

Affidavit of Raymond Sweeney, Director of the Office of Health Systems Management of the New York State Department of Health, July 11, 1988 (hereinafter "Sweeney Aff."), ¶14. In

---

[15] Justice Department Business Review Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, to B. William Dunlap, Ohio Hospital Association (June 9, 1982).

[16] Because I hold that the alleged conduct does not violate the antitrust laws, I need not reach the issue of whether Blue Cross would have a valid state action defense and make no decision thereon.

addition, the Superintendent of Insurance must (1) approve Blue Cross' subscriber contracts for hospital or medical coverage, N.Y.Ins.L. § 4308(a), (2) approve Blue Cross' subscriber premiums or the rating formula from which premiums are determined, N.Y.Ins.L. § 4308(b), and (3) hold a public hearing on any proposed community rate increases for hospital and medical coverage, N.Y.Ins.L. § 4308(c). *See*, Corcoran Aff. at ¶¶ 5-7. The state's supervision suggests that novel judicial applications of antitrust law are unlikely to be required to prevent Blue Cross from abusing its market power.

Third, to the extent that consumer welfare is the goal of antitrust,[17] a court should be hesitant to extend antitrust law to strike down a system that currently saves consumers about $25 million a year in radiology fees.[18]

Thus, Blue Cross has not violated Section 1 of the Sherman Act as alleged in the Radiologists' first claim for relief. The Radiologists' First Claim for Relief is hereby dismissed.

2. *Sherman Act § 2*

[2] The Radiologists also contend that Blue Cross' agreements with hospitals constitute monopolization or attempts to monopolize in violation of § 2 of the Sherman Act. For purposes of this motion, the Court will assume that Blue Cross has significant market power as a purchaser of hospital benefits and services.[19] The Radiologists argue that Blue Cross' use of its

---

[17] *See NCAA v. Board of Regents*, 468 U.S. at 107, 104 S.Ct. 2963; *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343, 99 S.Ct. 2326, 2333, 60 L.Ed.2d 931 (1979); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 486 n. 10, 97 S.Ct. 690, 696 n. 10, 50 L.Ed.2d 701 (1977); R. Bork, *The Antitrust Paradox* 7-9 (1978).

[18] "The real danger for the law is less that predation will be missed than that normal competitive behavior will be wrongly classified as predatory and suppressed." Bork, *supra*, at 157.

[19] The Court notes the difficulty in determining Blue Cross' market share. Blue Cross calculates its market share by determining the percentage of hospitals' net

(*Footnote continued*)

market power to extract favorable prices from hospitals has the purpose and effect of (1) injuring Blue *Cross*' competitors (other group purchasers of hospital services and benefits), and (2) injuring Blue *Shield*'s competitors (other group purchasers of medical services).

---

inpatient revenues attributable to Blue Cross; Blue Cross estimates its market share to be just over 20% using this calculation. Affidavit of Jerry Weissman, July 27, 1988, ¶ 40. Blue Cross bases its estimate on State Department of Health Reports, which it concedes include hospital revenues from all payors, including donations and payments from governments. Tr. at 46. The Radiologists counter with the deposition testimony of a few hospital administrators who estimate the percentage of their hospitals' total revenues attributable to Blue Cross to be approximately 30%. However, this figure represents Blue Cross' economic power in only a small percentage of the hospitals involved. The Radiologists deposed approximately six hospital administrators, only some of whom were asked about the percentage of funds attributable to Blue Cross; there are more than sixty hospitals in the Downstate area.

The Radiologists agree that the percentage of hospital revenues is the appropriate measure of Blue Cross' economic power over the *hospitals*, but argue that the appropriate measure of Blue Cross' market power vis-a-vis its competitors is the percentage of persons in the Downstate region who are covered by Blue Cross, *or* the percentage of persons in the Downstate region with medical coverage who are covered by Blue Cross. Tr. at 50-52. Using this calculation, the Radiologists estimate Blue Cross' market share at 80% to 90%. However, as Blue Cross pointed out at oral argument, "double counting" is in part responsible for its high market share. Many consumers are covered by more than one hospital insurance policy. Tr. at 56-57, 64. For example, some consumers may purchase 60-day Blue Cross hospital coverage, and supplemental coverage from another company. The Radiologists have counted anyone who has *some* Blue Cross coverage as a Blue Cross subscriber. The parties have not produced the information regarding Blue Cross' competitors' coverage that would be required to eliminate this double-counting (indeed, the information may be unavailable to them).

In addition, the parties disagree as to the inclusion of "uninsurables" in the number of persons covered by Blue Cross; there is no competition for these community rated subscribers. Blue Cross estimates that 45% of its subscribers are community rated subscribers.

The parties also disagree on the propriety of including Medicare funds in the calculation of Blue Cross' market share. Tr. at 46-47. Part A of Medicare provides hospital insurance coverage for individuals who qualify for monthly

(*Footnote continued*)

a. Injury to Blue Cross' Competitors

Even assuming that Blue Cross uses its market power to obtain favorable prices from hospitals, Blue Cross has not thereby violated Section 2 of the Sherman Act. The law does not prevent a buyer with market power from negotiating a good price, or from specifying what it will buy. "Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold." *Kartell*, 749 F.2d at 925. "Even if the buyer has monopoly power, an antitrust court . . . will not interfere with a buyer's (nonpredatory) determination of price. . . . A legitimate buyer is entitled to use its market power to keep prices down." *Id.* at 929; *see*, *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 297 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093, 100 S.Ct. 1061, 62 L.Ed.2d 783 (1980) (analogous conclusion with respect to *sellers* with market power). There is no evidence that Blue Cross has interfered in any way

---

Social Security benefits as well as for certain disabled persons. 42 U.S.C.A. § 1395c. Pursuant to 42 U.S.C. § 1395cc(a)(1)(A), Part A providers agree not to charge individuals covered by Medicare for the inpatient services rendered to them. Instead the providers accept reimbursement from the trust fund, in amounts calculated under Medicare regulations by the Health Care Financing Administration or, at the option of the provider, by private organizations under contract with HCFA. These private parties (fiscal intermediaries) act as agents of HHS in administering the Medicare Program.

Blue Cross is an approved Medicare fiscal intermediary. It is therefore responsible for the payment of substantial sums of Medicare funds to the hospitals. However, as a fiscal intermediary, Blue Cross serves only as a "conduit," and cannot resolve policy questions. *Heckler v. Community Health Services*, 467 U.S. 51, 64-65, 104 S.Ct. 2218, 2225-2226, 81 L.Ed.2d 42 (1984). The Radiologists point out, however, that since Blue Cross is the conduit for these funds, Blue Cross can control the timing of Medicare payments to hospitals. Tr. at 53. On the other hand, no hospital is required to select Blue Cross as its fiscal intermediary; at least sixteen hospitals in the Downstate New York area have chosen an approved fiscal intermediary other than Blue Cross.

Finally, the Court notes that it has been suggested that health insurers' bargaining power may not be as great as their size suggests, because pressure from their individual subscribers would prevent them from, *e.g.*, disallowing reimbursement at 90% of the hospitals in an area. "Joint Provider Activities Affecting Price," *supra*, at 74 n. 218.

with any competitor's ability to obtain similar terms from sellers. See p. 713 *ante*. In these circumstances, the Radiologists have presented no evidence that Blue Cross' use of its market power to extract low prices was unlawful.[20]

b. Injury to Blue Shield's Competitors

The Radiologists claim that one of the reasons Blue Cross insists on purchasing radiology services from hospitals is that it wants to use its leverage in one market (the hospital service and benefit insurance market) to gain a competitive advantage in a second market (the medical service insurance market), where its affiliate Blue Shield is weak. For purposes of this decision, the Court will assume that Blue Shield is less successful than Blue Cross.

The Radiologists have offered no evidence that Blue Cross' purpose in insisting on purchasing radiology services for its subscribers is to assist its weaker affiliate Blue Shield, and several facts make this argument implausible. There is no dispute that when a hospital patient has Blue Cross coverage, Blue Cross is always billed for the hospital radiology fees, and those fees are never billed to anyone else (whether the patients subscribe to Blue Shield or to a competitor of Blue Shield). Thus, Blue Shield's competitors benefit from Blue Cross' policy as much as does Blue Shield — none of them pays for radiology services for patients with Blue Cross coverage. Tr. at 33-34.

Second, there is no evidence indicating that (and it is illogical to assume that) consumers would select Blue Shield over a competing insurer because of some differential in premium costs that

---

[20] The Radiologists point to a remark by Mr. Lovett of Blue Cross, to the effect that direct billing by radiologists would imperil Blue Cross' market share (presumably by making Blue Cross coverage less valuable). Minutes of Meeting of Hospital Review Committee of Blue Cross and Blue Shield of Greater New York, April 4, 1984, at 4. Whether or not Mr. Lovett is correct, this statement alone is not probative of any unlawful conduct on the part of Blue Cross. Even if this remark showed an intention on Mr. Lovett's or Blue Cross' part to limit competition, ". . . an admitted intention to limit competition will not make illegal conduct that we know to be pro-competitive or otherwise immune from antitrust control." 7 Areeda, *supra* ¶ 1506 at 391.

might result from the fact that Blue Shield does not offer to pay its subscribers' in-hospital radiology bills. Since no medical insurer pays in-hospital radiology bills for Blue Cross subscribers, every medical insurer, not just Blue Shield, can offer two plans: one plan for non-Blue Cross subscribers, that pays in-hospital radiology bills, and a cheaper plan, for Blue Cross subscribers, that does not. The Radiologists admit that in reality Blue Shield's competitors do just that. Tr. at 32. Blue Shield gains nothing vis-a-vis its competitors by the inclusion of in-hospital radiology services in Blue Cross hospital benefits. There is thus no injury to competition in the medical service insurance market. In addition, because it is so unlikely, if not impossible, that Blue Cross' decision to purchase radiology services could injure competition in the medical service insurance market, it is highly improbable that Blue Cross' purpose in purchasing such services is to benefit Blue Shield.[21]

---

[21] Faced with the reality that Blue Shield gets no cost advantage from Blue Cross' purchase of radiology services, the Radiologists attempted to reformulate their theory of injury (this new theory was raised for the first time at oral argument on this motion, more than three and one-half years after this litigation began). They now argue that Blue Shield is a less efficient claims handler than its competitors, and that Blue Cross, by shielding Blue Shield from the need to process the Radiologists' bills, harms Blue Shield's competitors by making radiology bills "one area [in] which they do not get to demonstrate their competitive advantage, the better administration . . ." Tr. at 34. Thus, the Radiologists argue, Blue Shield gains a competitive advantage by having "one less area to screw up in." *Id.* In addition, while acknowledging that all medical insurers benefit from Blue Cross' purchase of radiology services, the Radiologists argue that if medical insurers had to pay radiology bills, the additional burden would be more costly for Blue Shield than for its competitors because Blue Shield is less efficient than its competitors; Blue Shield would then have to increase its premiums by a greater amount than would its competitors.

The Radiologists have offered no evidence that Blue Shield is less efficient than its competitors. After oral argument, the Radiologists submitted three documents purporting to demonstrate Blue Shield's inefficiency. Plaintiff's Post-Argument Affidavit, Exs. D, E, and F. Although these documents reflect some consumer dissatisfaction with *both Blue Cross and Blue Shield* (eg.: "Both carriers draw particularly heavy criticism on the time required to process claims, . . ." Plaintiff's Post-Argument Affidavit, Ex. E at VII), none of these documents

(*Footnote continued*)

In addition, Blue Cross had a policy of purchasing in-hospital radiology services long before Empire acquired Blue Shield in 1978. Thus, Blue Cross' *purpose* in *adopting* this policy could not have been to give Blue Shield an edge over Blue Shield's competitors.[22]

Thus, even assuming that Blue Cross has significant market power, Blue Cross has not violated Section 2 of the Sherman Act as alleged in the Radiologists' second and third claims for relief; accordingly, the Radiologists' Second and Third Claims for Relief are hereby dismissed.

CONCLUSION

Because I hold that the plaintiffs are not entitled to antitrust relief, I need not reach defendant's McCarran-Ferguson and state action defenses or plaintiffs' cross-motion for partial summary judgment with respect to those defenses. The state law claim must be dismissed for lack of pendent jurisdiction.

Accordingly, defendant's motion for summary judgment is hereby granted; this action is hereby dismissed with prejudice.

SO ORDERED.

---

contains any data concerning Blue Shield's costs or efficiency in comparison to Blue Shield's competitors. Any argument based on an assumption that Blue Shield would be inefficient in handling radiology claims as compared to Blue Shield's competitors is pure speculation and unsupported by evidence.

In addition, as with the Radiologists' original leveraging claim, there is no evidence that Blue Cross purchases radiology services for the purpose of denying Blue Shield this opportunity to fail.

[22] Even if Blue Cross decided in 1978 to *persist* in its long-standing policy, for the purpose of injuring Blue Shield's competitors, its persistence is not paying off. The number of Blue Shield subscribers has declined every year save one since its consolidation with Blue Cross. Defendant's Memorandum of Law in Support of Motion for Summary Judgment, p. 48. Its market share has declined as well. Even the Radiologists' counsel estimates that Blue Shield's market share in the medical service insurance market has fallen from 50% to 30% in the past five or ten years. Tr. at 32.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,	:	
Plaintiffs,	:	85 Civ. 2733 (SWK)
— against —	:	ORDER
EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,	:	
Defendant.	:	

Westchester Radiological Associates, P.C., *et al.* having commenced this action against Empire Blue Cross Blue Shield ("Empire") seeking damages and injunctive relief;

Empire having filed a motion to dismiss the action against it on the grounds that (1) the operation of the contracts between Empire and its member hospitals, as alleged in the complaint, do not constitute violations of the Sherman Act, (2) plaintiffs lack standing to challenge certain of the violations of the Sherman Act alleged in the complaint, and (3) accordingly, the Court lacks jurisdiction over the plaintiffs' pendent state law claims;

the court having denied that motion in its Memorandum Opinion and Order filed April 27, 1987, and Empire having requested that the Court reconsider its Memorandum Opinion and Order or, in the alternative, certify it for interlocutory appeal pursuant to 28 U.S.C. § 1292(b); and

the Court having considered the submissions of all parties, having declined to reconsider its Memorandum Opinion and Order and having found that said order involved controlling

questions of law as to which there is substantial ground for difference of opinion and that an immediate appeal would materially advance the ultimate termination of the litigation;

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED AS FOLLOWS:

The Memorandum Opinion and Order filed April 27, 1987, which denied Empire's motion to dismiss the complaint in its entirety is hereby certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b).

SO ORDERED.

SHIRLEY WOHL KRAM
UNITED STATES DISTRICT JUDGE

Dated: New York, New York
June , 1987

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al., Plaintiffs,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC., Defendant.

No. 85 Civ. 2733 (SWK).

United States District Court, S.D. New York

April 23, 1987.

Hospital-based radiologists brought action against nonprofit health insurance corporation organized under New York insurance law alleging unlawful restraint of trade, monopolization, and price fixing in violation of federal antitrust laws, as well as New York State law, on ground that corporation insisted that both technical component and professional component of radiological services provided to subscribers be treated as covered hospital service rather than as services provided by physician. Defendant moved to dismiss the complaint. The District Court, Kram, J., held that: (1) proposition that buyers and sellers may negotiate about terms of purchase without violating antitrust laws did not apply where buyer, a nonprofit health insurance corporation organized under New York insurance law had no contractual relations with the sellers, the hospital-based radiologists, and (2) radiologists had standing to pursue claims.

Motion denied.

MEMORANDUM OPINION AND ORDER

KRAM, District Judge.

This is an action under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and the Donnelly Act, N.Y.Gen.Bus.Corp.Law § 340. Plaintiffs allege unlawful restraint of trade, monopolization, and price fixing in violation of the federal antitrust laws as well as New York State law. Plaintiffs seek injunctive and treble damage relief. The case is presently before the court on defendant's motion to dismiss the complaint, pursuant to Rule 12(b)

of the Federal Rules of Civil Procedure, on the grounds: (1) that plaintiffs' claim under Section 1 of the Sherman Act fails to state a claim under the antitrust laws upon which relief can be granted; (2) that plaintiffs lack standing to maintain an action based on their claims under Section 2 of the Sherman Act; and (3) that, as a result, this Court lacks jurisdiction to consider plaintiffs' pendent state law claim. For the reasons set forth below, defendant's motion is denied.

FACTS

The basic facts are not in dispute. Plaintiffs are a majority of the hospital-based radiologists (the "Radiologists") who work in the seventeen counties in and around New York City ("Downstate New York"). Defendant Empire Blue Cross and Blue Shield, Inc. ("Empire") is a non-profit health insurance corporation organized and existing under Article 43 of the New York Insurance Law. Empire is the product of a merger of Blue Cross/Blue Shield of Greater New York, Inc., which served Downstate New York, and Blue Cross of Northeastern New York, Inc., which served the Northeastern New York area.

Empire offers two basic insurance plans: (1) "Blue Cross," which covers certain defined hospital benefits, and (2) "Blue Shield," which covers professional medical services provided by physicians. Empire provides Blue Cross hospital service benefit coverage to more than 9 million covered persons. In order to provide inpatient hospital services under these subscriber contracts, Empire has contracts with hospitals whereby the hospitals accept state regulated payments from Empire as full reimbursement for such services and may not seek to collect additional charges from Empire's subscribers. Empire does not pay on the basis of the particular hospital services that may be rendered to a particular patient; instead, Empire makes a "per diem" payment calculated on the basis of the hospital's overall expenses as incurred in a previous "base" year.

Empire's Blue Shield plan, on the other hand, covers bills for physicians' services actually rendered to a patient, whether in

the hospital, the examining room or the home. "Participating" physicians send their bills to Empire, and Empire pays the physician an agreed-upon amount for the services rendered. "Non-participating" physicians send their bills directly to a subscriber, who, in turn, is reimbursed by Empire in the same amount it would have paid had the physician been a participant. Subscribers are then left to pay any difference in cost. In either case, the physician bills for specific services as performed, and the size of his fee depends on the nature of those services.

Radiologists are licensed physicians who have completed special residency programs in radiology[1] and have thereby become qualified in that particular medical specialty. The Radiologists, pursuant to agreements which they have maintained with various hospitals in Downstate New York, practice on hospital premises, as opposed to in private offices.

In general, health insurance plans allow hospital-based radiologists to direct-bill their patients — or their patients' medical insurance carriers — for diagnostic — but not technical — radiological services actually rendered by a radiologist in a hospital. In Downstate New York, however, the hospital-based Radiologists receive compensation for their services directly from the hospitals. Such compensation is included as a cost in the computation of the Blue Shield per diem reimbursement rate paid by Empire to these hospitals.

According to the Radiologists' complaint, Empire alone insists that both the technical component and the professional component of radiological services provided to Blue Cross subscribers be treated as a covered hospital service under its Blue Cross plan, and, as a result, the Radiologists are compelled to accept reimbursement from the hospitals for services provided subscribers at levels substantially lower than would have prevailed in the absence of Empire's unlawful acts and in freely competitive

---

[1] The Second Amended Complaint defines "radiology" as "the medical specialty concerned with the diagnostic and therapeutic use of x-rays, radium rays and other forms of radiant energy or its equivalent, in the diagnosis and treatment of disease or injury."

conditions. In other words, if Empire would agree to let radiologists bill directly for the professional/diagnostic component of their services – as all other physicians allegedly are allowed to do – they could make more money. Indeed, the Radiologists specifically claim that the clear and intended effect of Empire's policy[2] is to reduce hospital-based radiologists' income in Downstate New York by some $25 million per year so as to preserve the attractiveness of its Blue Cross coverage as against its hospital insurance competitors and avoid saddling the Blue Cross plan with the need to raise its premiums and lose business to its competitors.

---

[2] Empire explains that:

> In 1969, however, the New York Legislature became convinced that retrospective reimbursement failed to encourage the hospitals to control their costs, which were increasing at an alarming rate. As a result, the Legislature revised Chapter 28 of the Public Health Law, which set forth the procedure for determining hospital reimbursement, and directed the Commissioner of Health to develop an "effective cost control program" that would "both enable and motivate hospitals to control their spiraling costs" (Chapter 957, 1969 N.Y. laws). Given this mandate, the Commissioner developed regulations, now codified as NYCRR § 86-1.1, *et seq.* (the "Regulations" or "Part 86"), that established the system of "prospective" reimbursement that remains in use in New York State.
>
> Instead of paying the hospital for the charges for all items of care rendered to each individual patient, under a prospective methodology Blue Cross pays a set amount to the hospital for each "patient day" of care rendered to a person with Blue Cross hospital coverage. That amount, referred to as the "*per diem* reimbursement rate" in paragraph 12 of the Complaint, is established annually for each Downstate Hospital on the basis of financial data it supplies and is provided to each hospital in advance of the rate year so that each may have an opportunity to plan its budget accordingly. If, during the rate year, a hospital's cost of providing care is less than the *per diem*, the hospital retains the difference. If the cost of care is greater than the payment rate, the hospital absorbs the difference. Thus, prospective reimbursement gives the hospitals an incentive to reduce waste and to make their own operations more efficient.

As a result, the Radiologists allege (1) that Empire has, in combination and concert with the hospitals in Downstate New York, fixed prices and otherwise restrained the manner in which the Radiologists bill for their time in violation of Section One of the Sherman Act, (2) that injury to the Radiologists is the precisely intended consequence of, and is inextricably intertwined with Empire's attempted monopolization of the hospital insurance market and its leveraging of that monopoly into an anticompetitive advantage in the medical insurance market in violation of Section 2 of the Sherman Act, and (3) that, as a result, Empire also has violated New York State antitrust law.

DISCUSSION

Empire, accepting the factual allegations in the complaint as true for the purposes of its motion, moves to dismiss on three grounds. First, Empire argues that the complaint fails to state an antitrust claim because Empire's contracts with the hospitals are merely arrangements for the purchase of goods and services by Empire and antitrust law usually permits a legitimate buyer to use its market power to keep prices down. Second, Empire contends that, because the Radiologists are neither consumers nor competitors in the relevant market, they lack standing to pursue an action for abuse of monopoly power in that market. Third, Empire argues that jurisdiction over the New York State Donnelly Act claim is pendent to the federal antitrust claims and must fail for want of federal jurisdiction once the Radiologists' federal claims have been dismissed.

The Section One Claim

Section 1 of the Sherman Act provides in relevant part that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations is declared to be illegal." 15 U.S.C. § 1. In relation to the health insurance field, the weight of authority holds that a contract that sets the price for services between a buyer—such as Empire—and a seller—such as a hospital, a physician, a psychotherapist or a pharmacy—is neither per se illegal nor an unreasonable restraint

of trade under Section 1. *E.g.*, *Brillhart v. Mutual Medical Insurance, Inc.*, 768 F.2d 196 (7th Cir. 1985); *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322 (1985); *Royal Drug Co. v. Group Life & Health Insurance Co.*, 737 F.2d 1433 (5th Cir.1984), *cert. denied*, 469 U.S. 1160, 105 S.Ct. 912, 83 L.Ed.2d 925 (1985); *Klamath-Lake Pharmaceutical Association v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir.1983), *cert. denied*, 464 U.S. 822, 104 S.Ct. 88, 78 L.Ed.2d 96 (1983); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2d Cir.1982) (per curiam); *Webster County Memorial Hospital, Inc. v. United Mine Workers of America Welfare & Retirement Fund of 1950*, 536 F.2d 419 (D.C.Cir. 1976) (per curiam); *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 603 F.Supp. 1077 (S.D.Ind.1985), *aff'd*, 784 F.2d 1325 (7th Cir.1986); *Sausalito Pharmacy, Inc. v. Blue Shield*, 544 F.Supp. 230, *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016, 103 S.Ct. 376, 74 L.Ed.2d 510 (1982); *Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cas. (CCH) ¶ 64,801 (E.D.Mich.1982); *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D.Mich.1980).

Relying on the *Kartell* line of cases, Empire argues that the Radiologists' Section One claim should be dismissed on the grounds that:

> In essence, then, the lawfulness of the term in question stems from the fact that it is an essential part of the price bargain between the buyer and seller. Whether or not that price bargain is, in fact, reasonable is, legally speaking, beside the point, even in the case of a monopolist. As Blue Shield stresses in its brief, health maintenance organizations, independent practice associations and preferred provider organizations all routinely agree with doctors that the doctors will accept payment in full for services rendered to its subscribers. We can find no relevant

> analytical distinction between this type of purchasing decision and the practice before us — even on the assumption that Blue Shield possesses market power.

Kartell, 749 F.2d at 928-29. As a result, Empire contends that it can legally hold to its longstanding arrangements with the hospitals to the effect that radiological services for persons it covers are the responsibility of the hospitals to provide and purchase.

[1] The Radiologists, however, rightly contend that the *Kartell* line of cases, which stands for the proposition that buyers and sellers may negotiate about the terms of purchase without violating the antitrust laws, is inapposite here where the buyer (Empire) has no contractual relations with the sellers (the Radiologists) and has not negotiated for any. Rather, the crucial agreement here, whereby Empire allegedly compels the hospitals to prevent the direct billing of Blue Cross subscribers for the Radiologists' diagnostic services, is between Empire and the hospitals, *not* Empire and the Radiologists. This triangular relation — with Empire intervening as a third force — is expressly excluded from the holding in the *Kartell* line of cases:

> To find an unlawful restraint, one would have to look at [Empire] as if it were a "third force," intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains.

Kartell, 749 F.2d at 924.

In other words, although buyers may permissibly bargain with sellers, if the insurance plan in *Kartell* had not dealt bilaterally with the physician-sellers of medical services but instead had acted as an inhibitory "third force" interfering in a separate buyer/seller relationship involving other persons, the relationship would not have been exempt from antitrust scrutiny. That, of course, is precisely the present case; Empire here is charged with intervening in the relationship between the Radiologists and the hospitals so as to prevent hospital-based radiologists from direct billing their patients for professional medical services.

Accordingly, Empire's motion to dismiss the Radiologists' Section One claim on the ground that the Kartell line of cases is dispositive of that claim is denied.

The Section Two Claims

With respect to claims under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, courts have grafted a doctrine of standing onto the sweeping language of Section 4 of the Clayton Act, 15 U.S.C. § 15. *Crimpers Promotions Inc. v. Home Box Office, Inc.*, 554 F.Supp. 838, 842 (S.D.N.Y. 1982), *aff'd*, 724 F.2d 290 (1983). Section 4 of the Clayton Act permits "[a]ny person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws" to sue for treble damages recovery in federal district court. 15 U.S.C. § 15.

The Supreme Court most recently addressed questions of antitrust standing in *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 102 S.Ct. 2540, 73 L.Ed.2d 149 (1982), and *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 103 S.Ct. 897, 74 L.Ed.2d 723 (1983). In *McCready*, the Supreme Court acknowledged two types of limitations on the availability of the Section 4 remedy to particular classes of persons and for redress of particular forms of injury: (1) limitations designed to prevent double recovery, and (2) limitations where the injuries are "too remote" from the antitrust violation to afford standing. *McCready*, 457 U.S. at 472-78, 102 S.Ct. at 2544-47. In *Associated General*, the Supreme Court found certain other factors also to be relevant to the question of antitrust standing: (1) whether the alleged injury resulted from anaticompetitive activity, i.e., was of the type sought to be prevented by the antitrust laws, (2) whether the asserted injury was direct or indirect, (3) whether there existed an alternative plaintiff "whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement," (4) whether the nature of the damages was speculative, and (5) whether there was danger of double recovery. *Associated General*, 459 U.S. at 535-44, 103 S.Ct. at 907-11. *See also Donahue v. Pendleton Woolen Mills, Inc.*, 633 F.Supp. 1423,

1432 (S.D.N.Y.1986); *Rosenberg v. Gottlieb, Steen & Hamilton*, 598 F.Supp. 642, 644-45 (S.D.N.Y.1984).

Associated General also advises federal courts to abstain from black letter rules and to analyze the facts in each case. *Id.*, 459 U.S. at 536 n. 33, 103 S.Ct. at 907 n. 33; *Crimpers Promotions, Inc. v. Home Box Office, Inc.*, 724 F.2d 290, 293 (2d Cir.1983). In light of this admonition, the Second Circuit, which previously had followed the "target area" approach to such determinations, provided that:

> While we do not hold that *Calderone [Enterprises Corp. v. United Artists Theatre Circuit, Inc.*, 454 F.2d 1292 (2d Cir.1971), *cert. denied*, 406 U.S. 930, 92 S.Ct. 1776, 32 L.Ed.2d 132 (1972),] and *Billy Baxter [, Inc. v. Coca-Cola Co.*, 431 F.2d 183 (2nd Cir.1970), *cert. denied*, 401 U.S. 923, 91 S.Ct. 877, 27 L.Ed.2d 826 (1971),] have been drained of their precedential vitality on their own or very similar facts, we think that in approaching new problems, courts of this circuit would do better, indeed are compelled, to follow the approaches adumbrated by the Supreme Court in *McCready* and *Associated General* without concern whether the results are consistent with language in earlier Second Circuit cases.

Crimpers Promotions, 724 F.2d at 293.

Empire contends here that the Radiologists monopoly claims under Section 2 must be dismissed as the Radiologists lack standing to challenge Empire's alleged monopolization of the hospital insurance market and its monopoly leveraging of the medical insurance market. Specifically, Empire argues that the Radiologists are neither consumers nor competitors in the hospital insurance market and that there is an identifiable class of persons—namely the private competing health insurance companies—whose self-interest normally would motivate them to vindicate the public interest and bring such an action. As

a result, Empire contends that, pursuant to *Associated General*, the Radiologists lack standing to commence this antitrust action.

[2, 3] Empire's arguments are unavailing. An antitrust plaintiff need not be either a competitor or a consumer in the relevant market in order to have antitrust standing. *McCready*, 457 U.S. at 483-84 & n. 21, 102 S.Ct. at 2250-51 & n. 21; *Crimpers Promotions*, 724 F.2d at 296 n. 6. Furthermore, the Court has analyzed the *McCready* limitations and the *Associated General* factors relative to this case and determines that the Radiologists do indeed have standing to pursue their Section 2 claims.

There is no potential here for double recovery by the Radiologists as their losses are readily separable from any competitive disadvantage suffered by another insurer. Nor are their alleged injuries too remote from the alleged antitrust violations to afford standing; indeed, their alleged injuries are the "precisely intended consequence" of Empire's alleged antitrust violations and are "inextricably intertwined" with the advantages Empire allegedly seeks to gain against its competitors. *Crimpers Promotions*, 724 F.2d at 294-95. As a result, the *McCready* limitations are not a bar to standing here.

The Radiologists also succeed under the factors enunciated in *Associated General*. First, the alleged injury results from Empire's alleged anticompetitive conduct. Second, the Radiologists alleged injury is directly related to Empire's alleged anticompetitive benefit and is specifically directed against the Radiologists. Third, because the Radiologists allegedly are the targets of Empire's conduct, they are the logical plaintiffs to bring this action. In addition, the impact of Empire's alleged conduct on the competing insurers, which are other potential plaintiffs identified by Empire, may indeed not be sufficiently injurious to the competing insurers for them to undertake the time and expense of litigation. Fourth, the Radiologists' damages appear readily calculable in that the Radiologists' records will reflect what services they performed for Blue Cross subscribers and what the comparable billings for those services should have

been based on direct billings under other health insurance policies. Fifth, there is no risk of duplicate recovery.

In sum, the Radiologists satisfy the antitrust standing requirements of both *McCready* and *Associated General*, and are clearly appropriate plaintiffs in this antitrust action. Accordingly, Empire's motion to dismiss the Radiologists' Section 2 claims for lack of standing is denied.

The Donnelly Act Claim

[4] Jurisdiction over Donnelly Act claims is pendent to, and thus derives from, the federal antitrust claims. Because Empire's motion to dismiss the federal claims is denied, the Court also maintains federal jurisdiction over the Radiologists' Donnelly Act claim.

CONCLUSIONS

Accordingly, for the reasons outlined above, Empire's motion to dismiss the complaint pursuant to Rule 12(b) of the federal Rules of Civil Procedure is denied in its entirety.

SO ORDERED.

No. 89-941 (2)

Supreme Court, U.S.
FILED
JAN 10 1990
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,

Petitioners,

—v.—

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

ROBERT A. BICKS
BREED, ABBOTT & MORGAN
153 East 53rd Street
New York, New York 10022
(212) 888-0800
Counsel of Record for Respondent

Of Counsel:
ROBERT A. BICKS
HOWARD S. WOLPSON
BREED, ABBOTT & MORGAN
153 East 53rd Street
New York, New York 10022
(212) 888-0800

COUNTERSTATEMENT OF QUESTION PRESENTED

Should this Court invoke its certiorari jurisdiction to review the holding of a unanimous court of appeals, speaking *per curiam*, that Blue Cross' long-standing coverage of inpatient diagnostic radiological services under its subscriber contracts for hospital insurance does not run afoul of the Sherman Act?

TABLE OF CONTENTS

	Page
COUNTERSTATEMENT OF QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
COUNTERSTATEMENT OF THE CASE	4
A. Origins of the Present Controversy	5
B. Bases for Empire's Policy	6
C. Proceedings Below	6
REASONS FOR DENYING THE WRIT	7
1. Blue Cross' Purchase of Hospital Services, in a Cost Effective Manner, on Behalf of its Subscribers Does Not Run Afoul of the Sherman Act	7
2. This Conclusion Holds Whatever Blue Cross' Market Power May Be	9
3. This Basic Bears with Especial Force in the Regulated Context Within Which Empire Functions	10
4. Whether a Particular Hospital Official May Like or Dislike Present Arrangements with Blue Cross Likewise Should Make No Difference	12
CONCLUSION	14

TABLE OF AUTHORITIES

Cases	Page
Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982)	3 n.3
Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585 (1985)	2, 3, 11
Ball Memorial Hosp. Ins., Inc. v. Mutual Insurance, 784 F.2d 1325 (7th Cir. 1986)	9
Brillhart v. Mutual Medical Ins., Inc., 768 F.2d 196 (7th Cir. 1985)	8 n.7
Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979)	8 n.7
Kartell v. Blue Shield, Inc., 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985)	3 n.3, 8 n.7
Lorain Journal Co. v. United States, 342 U.S. 143 (1951)	2
Medical Arts Pharmacy, Inc. v. Blue Cross & Blue Shield, Inc., 675 F.2d 502 (2d Cir. 1982)	8 n.7
Ocean State Physicians Health Plan v. Blue Cross, 883 F.2d 1101 (1st Cir. 1989)	8, 8 n.7, 9
Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 815 F.2d 270 (3d Cir.), *cert. denied*, 484 U.S. 851 (1987)	8 n.7
Presbyterian Hosp. v. Ingraham, 39 N.Y.2d 867, 386 N.Y.S.2d 217, 352 N.E.2d 135 (1976)	5, 13 n.12
Presbyterian Hosp. v. Ingraham, 48 A.D.2d 491, 369 N.Y.S.2d 738 (1st Dep't 1975), *aff'd*, 39 N.Y.2d 867, 386 N.Y.S.2d 217, 352 N.E.2d 135 (1976)	13 n.12
SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65 (1959)	14

Page

U.S.F.L. v. N.F.L., 842 F.2d 1335 (2d Cir. 1988) 10

United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377 (1956)..... 12

Rules and Statutes

Sherman Act § 1, 15 U.S.C. § 1 (1982)..... 6

Sherman Act § 2, 15 U.S.C. § 2 (1982).....3, 6, 9, 11, 12

McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* (1982) 14

N.Y. Ins. Law § 4308(a) (McKinney 1985).....10 n.10

N.Y. Ins. Law § 4308(b) (McKinney Supp. 1989).....10 n.10

N.Y. Ins. Law § 4308(c) (McKinney 1985).....10 n.10

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-941

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,

Petitioners,

—v.—

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

None of the reasons advanced by petitioners to justify certiorari suffices to merit review by this Court.

1. Affirming grant of summary judgment in favor of respondent Empire Blue Cross and Blue Shield, Inc. ("Empire"), the ruling of the Court of Appeals conflicts with no decision of this Court or of any court of appeals. In essence, this case arises from the fact that in order to make good on its Blue Cross service benefit hospitalization insurance, Empire purchases covered services for its subscribers from hospitals at rates prescribed by the State of New York (JA 138 n.9; JA 23, ¶ 29);[1] and this State-set rate has long included as part of each hospi-

---

1 JA _____ denotes reference to the Joint Appendix filed in the Court of Appeals. A-_____ denotes reference to the Appendix to the Petition for a Writ of Certiorari.

tal's reimbursement certain inpatient radiological services.[2] Thus, radiologists may not collect from Blue Cross subscribers directly for services Empire has already paid for on their behalf. It is this inability to "direct bill" for inpatient diagnostic radiological services that the complaint at bar challenges.

Dismissing this claim, the opinion of the District Court for the Southern District of New York, which the Court of Appeals adopted as its own, concluded that "[c]ourts have consistently rejected, in the health insurance context, the argument . . . that the antitrust laws give providers of goods and services a right to bill directly patients who are Blue Cross or Blue Shield subscribers." (A-11-12.) "Blue Cross is simply acting as a rational buyer attempting to get the best possible terms for its subscribers." (A-16 (footnote omitted).) And the " 'antitrust laws do not prohibit a buyer from bargaining for the best deal possible.' " (A-16 n.13.) Particularly so since "the Blue Cross system under attack here promotes cost containment in an area in which the government has recognized the need for cost containment," (A-16) and "is supervised by State regulators." (A-17.) Finally, "to the extent that consumer welfare is the goal of antitrust, a court should be hesitant to extend antitrust law to strike down a system that currently saves consumers about $25 million a year in radiology fees." (A-18 (footnotes omitted).) This holding presents no novel or unresolved issue of law appropriate for decision by the Court.

2. Urging to the contrary, petitioners' repeated incantation of *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985), and *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), is bewildering. *Aspen Skiing* rested on a "record . . . [that] comfortably supports an inference that the monopolist made a deliberate effort to discourage its customers from doing business with its small rival." *Id.* at 610. Similarly, liability in *Lorain Journal* rested on a finding that defendant's pattern of conduct was " 'bold, relentless, and predatory.' " *Lorain Journal Co. v. United States*, *supra*, 342 U.S. at 149

---

2 As the district court explained, the "radiology services here at issue are "noninterventional (*i.e.*, nonsurgical) inpatient diagnostic and therapeutic radiological services." (A-7 n.1.)

(quoting opinion below, 92 F. Supp. 794, 796 (N.D. Ohio 1950)). These cases stand at the pole opposite to the facts acknowledged as true by petitioners: as their complaint itself avers, Empire's purpose in covering disputed radiological services under its hospitalization insurance, and as a result purchasing such services directly from hospitals, is simply to make such coverage "attractive and desirable" to its subscribers, (JA 9-17, ¶ 35), ends which the antitrust laws would promote, not prohibit. Absent, therefore, is any showing—prerequisite to violation of Sherman Act § 2—that "the challenged conduct is fairly characterized as 'exclusionary' or 'anticompetitive' . . . or 'predatory,' to use a word that scholars seem to favor." *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, *supra*, 472 U.S. at 602.[3]

3. Summary judgment rested, not on disputed inferences of fact, but rather on petitioners' admissions. As the district court emphasized, "at oral argument the Radiologists' counsel admitted that" (A-15)

— there is "no evidence that Blue Cross has done anything to prevent its competitors from negotiating with hospitals to buy the same bundle of services that Blue Cross buys" (*id.*);

— there is "no evidence that Blue Cross has attempted to control agreements between the hospitals and other insurers" (*id.*);

---

3 Also a mystery is petitioners' reliance on *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), since Empire nowhere suggests that price-fixing of medical services is immune from antitrust scrutiny. *Maricopa* involved a horizontal agreement among physicians that fixed prices for their services, a *per se* violation of the Sherman Act. The Court rejected the physicians' argument that good intentions saved an otherwise illegal arrangement. *Id.* at 351. Blue Cross' agreements with hospitals, by way of contrast, involve legitimate arrangements for the purchase of a package of services, approved by the State Superintendent of Insurance (JA 24, ¶ 33), at prices set by the State Department of Health. (JA 128, ¶ 14.) The short of the matter is that "*Maricopa* is simply not on point." *Kartell v. Blue Shield, Inc.*, 749 F.2d 922, 930 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985).

— there is "no evidence that Blue Cross interferes in any way with the relationship between the radiologists and patients who are not covered by Blue Cross" (*id.*);

— there is "no evidence that Blue Cross directly tells, or even suggests to, the hospitals what to pay radiologists" (A-15-16); and

— "Blue Shield's competitors [in medical insurance] benefit from Blue Cross' policy as much as does Blue Shield—none of them pays for radiology services for patients with Blue Cross coverage. * * * * There is thus no injury to competition in the medical service insurance market." (A-21-22.)

— In sum, there is "no evidence that Blue Cross' use of its market power to extract low prices was unlawful." (A-21 (footnote omitted).)

COUNTERSTATEMENT OF THE CASE

Plaintiffs-petitioners are 58 individuals or "professional corporations, partnerships or similar organizations composed of hospital-based radiologists in active practice in the seventeen [downstate] counties" that comprise the greater New York metropolitan area. (JA 9-1-9-31.) Each plaintiff has the exclusive right to provide "radiological services to patients at a hospital . . . pursuant to an agreement with the hospital." (JA 9-4-9-5.)

Empire, the sole defendant-respondent, is a product of the 1974 consolidation of the downstate area's Blue Cross and Blue Shield plans and the 1985 merger with Blue Cross of Northeastern New York, Inc. (JA 131 n.1.)[4] Under New York law, such

4 Respondent Empire Blue Cross and Blue Shield, Inc. is a not-for-profit health service corporation organized and operating pursuant to Article 43 of the New York State Insurance Law. Empire has no parent companies and owns stock in the following subsidiaries: Access America, Inc., BCS Financial Corp., Dental Network of America, Inc., Health Information Reporting Company and Plans Liability Insurance Co. This statement is made pursuant to Rule 28.1 of the Rules of this Court.

plans do not "fall into the usual categories of regulated private enterprises or regulated public utilities. They are quasi-public corporations emburdened with public responsibilities offset by governmentally granted privileges and tax exemptions." *Presbyterian Hosp. v. Ingraham*, 39 N.Y.2d 867, 868, 386 N.Y.S.2d 217, 218, 352 N.E.2d 135 (1976). Empire today provides hospital service (or "Blue Cross") benefits coverage to more than nine million, and medical indemnity (or "Blue Shield") protection to some three million, covered persons principally situated within New York's seventeen downstate counties. (JA 130-31, ¶ 2.)[5]

A. Origins of the Present Controversy

In essence, petitioners seek to have compensation for their inpatient diagnostic services shifted from Blue Cross hospital coverage, where petitioners are paid by the hospital at which each works and where Empire's reimbursement to each hospital is set by the State of New York, to Blue Shield medical coverage, where each petitioner can directly bill each patient whatever the traffic will bear.

As New York's Superintendent of Insurance explained, the Blue Cross "hospital benefit package . . . is now subject to state regulation for the purpose of controlling hospital costs and thereby subscriber premiums." (JA 24, ¶ 33.) But the same does not go for doctors' bills "to Blue Shield subscribers,

---

5 Blue Shield's medical coverage typically pays dollar benefits equal to the physician's "usual and customary" fee. Empire's Blue Cross hospital coverage, on the other hand, provides service—rather than cash—benefits: days of hospital care in any member hospital, up to a prescribed number varying with the coverage purchased, rather than dollars. (JA 17, ¶ 12.) Since practically all hospitals in this area are members, a Blue Cross subscriber can go to whatever institution an attending physician recommends, no matter what its charges may be, and payment becomes Blue Cross' problem—not the subscriber's. (JA 138-39, ¶ 14.) Thus, in the Insurance Department's words, "[s]ervice benefit coverage makes hospital costs a prime concern for Blue Cross plans such as Empire and a prime concern of the Insurance Department." (JA 17, ¶ 13.)

[which] by way of sharp contrast, are not subject to a state program involving rigorous cost control." (JA 23-24, ¶ 32.)

B. Bases for Empire's Policy

Since Blue Cross' founding in the 1930's, its contracts with downstate New York subscribers (each approved by the Superintendent of Insurance prior to issuance) have covered inpatient diagnostic radiological services, and Blue Cross has purchased such services directly from member hospitals. This leaves radiologists in the same position as many other vendors of goods and services required by hospitals, including hospital-based professionals such as interns, resident physicians and registered nurses as well as other physicians providing, for example, pathology and certain cardiology services.

Empire has stood by its comprehensive Blue Cross hospital coverage because any cutback would mean proliferation of separate billing to Empire's Blue Shield subscribers, as well as freeing of radiologists' fees from New York's strict regulatory controls over reimbursement by Empire to hospitals. Further, to Empire's view, each hospital is better equipped to negotiate with its radiologists than would be a subscriber patient, who typically has no idea of the identity of the hospital's radiologist when admitted, who thereafter has no choice in the radiologist who happens to read his X-ray, and who most likely never knows which radiologist did so.

C. Proceedings Below

It was Empire's unwillingness to unbundle the package of hospital services it promises to its subscribers that triggered this complaint, under Sherman Act §§ 1 and 2, on which the district court (per Wood, J.) granted summary judgment in favor of Empire. (A-5-23.)[6] The Court of Appeals for the Second Cir-

---

6 Before this Court petitioners assert for the first time that "[t]his case arises out of a decision made in April 1984 by Empire" (Petition at 2). This despite the fact that, as far back as 1948, the radiologists challenged the legal basis for the Blue Cross policy at bar. At that time,

(footnote continued)

cuit affirmed *per curiam* "for the reasons stated in Judge Wood's well-reasoned opinion." (A-4.)

REASONS FOR DENYING THE WRIT

The ruling below simply applies settled antitrust doctrine, in the particular context of New York State's pervasive scheme for regulation of health insurance, to uphold Empire's long-standing coverage of inpatient diagnostic radiological services under its Blue Cross hospitalization policy. This record thus gives rise to no issue of law worthy of review by this Court.

1. Blue Cross' Purchase of Hospital Services, in a Cost Effective Manner, on Behalf of its Subscribers Does Not Run Afoul of the Sherman Act.

The court below found that "[f]or antitrust purposes Blue Cross is treated as a buyer where it pays the bill and seeks to set the amount to be charged." (A-12 n.6.) As New York State's Superintendent of Insurance concluded (JA 17, ¶ 12):

> In effect, then, Empire purchases hospital care on behalf of its subscribers.

In this context, the court's finding accords with the judgment of every court that has reviewed the operations of a Blue Cross or Shield plan and—without exception—determined that each

---

radiologists and other hospital-based physicians raised the "contention" that radiological services "are 'medical' services and may not be included in 'hospital' service furnished by hospital corporations" like Blue Cross. *See* 57 Op. Att'y Gen. 183, 184 (1948) (JA 587-88). The Attorney General of the State of New York, in response to a request for his Opinion from the Insurance Department "as to whether a hospital service corporation organized and operating in this State under Article IX-C of the Insurance Law may furnish to subscribers radiology . . . services as part of hospital service," concluded that "a hospital service plan may properly furnish to subscribers radiology . . . as a part of hospital service." (JA 588-89.)

functions as a purchaser of services on behalf of its subscribers.[7]

The court below did recognize that "here there is one more intermediary interposed between the physician and the patient, *i.e.*, the hospital." (A-13 (footnote omitted).) But it (A-14):

> is difficult to see why this fact should have any antitrust significance. . . . Although *Kartell* contains what this Court reads as a jocular reference to a sinister "third force," there is no authority whatever for the proposition that a seller has an *antitrust* remedy where a buyer insists upon buying his services through an intermediary. (Emphasis in original; footnote omitted.)[8]

In short, Blue Cross "the insurer—like any buyer of goods and services—is lawfully entitled to bargain with its providers for the best price it can get." *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1111 (1st Cir. 1989).

---

7 *See, e.g., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979) ("[t]he Pharmacy Agreements . . . are merely arrangements for the purchase of goods and services by Blue Shield"); *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1111 (1st Cir. 1989) ("for antitrust purposes, a health insurer like Blue Shield must be viewed 'as itself the purchaser of the doctors' services' "); *Pennsylvania Dental Ass'n v. Medical Serv. Ass'n*, 815 F.2d 270, 272 (3d Cir.), *cert. denied*, 484 U.S. 851 (1987) ("[t]hus, the economic effect of becoming a participating dentist is to agree to sell services to Blue Shield for its subscribers at what in many cases will be a discount"); *Medical Arts Pharmacy, Inc. v. Blue Cross & Blue Shield, Inc.*, 675 F.2d 502, 505 (2d Cir. 1982) ("Blue Cross was the purchaser of the prescribed drugs"); *Kartell v. Blue Shield, Inc.*, *supra*, 749 F.2d at 925 ("Blue Shield in essence 'buys' medical services for the account of others"); *Brillhart v. Mutual Medical Ins., Inc.*, 768 F.2d 196, 199 (7th Cir. 1985) ("[s]ince the agreement in the present case runs between an insurance company (the buyer) and individual doctors (the sellers), the arrangement is really vertical").

8 Otherwise, for one example, any auto manufacturer that chooses to purchase an assembled engine, rather than each engine component separately from its maker, could be charged under the Sherman Act. The same would also go for an aircraft producer that buys wing sections from assemblers rather than itself purchasing each of the various parts which its wing section supplier purchases and utilizes.

2. This Conclusion Holds Whatever Blue Cross' Market Power May Be.

The district court assumed that "Blue Cross has significant market power as a purchaser of hospital benefits and services." (A-18 (footnote omitted).) From this assumption the court went on to conclude that: "Even assuming that Blue Cross uses its market power to obtain favorable prices from hospitals, Blue Cross has not thereby violated Section 2 of the Sherman Act." (A-20.)

Its reasoning to such end commends itself:

> "Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold." *Kartell*, 749 F.2d at 925. "Even if the buyer has monopoly power, an antitrust court . . . will not interfere with a buyer's (nonpredatory) determination of price. . . . A legitimate buyer is entitled to use its market power to keep prices down." *Id.* at 929; *see*, *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 297 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093, 100 S. Ct. 1061 (1980) (analogous conclusion with respect to *sellers* with market power). (A-20.)

Because "[t]he antitrust laws are for the benefit of competition, not competitors," it follows that "[e]ven the largest firms may engage in hard competition, knowing that this will enlarge their market share." *Ball Memorial Hosp. Ins., Inc. v. Mutual Insurance*, 784 F.2d 1325, 1338-39 (7th Cir. 1986). "As long as Blue Cross' course of conduct was itself legitimate, the fact that some of its executives hoped to see" a larger market share "is irrelevant." *Ocean State*, *supra*, at 1113.[9] " 'Under the anti-

---

9 This disposes of what petitioners call their "smoking gun". As the district court reasoned (A-21 n.20):

> The Radiologists point to a remark by Mr. Lovett of Blue Cross, to the effect that direct billing by radiologists would imperil Blue Cross' market share (presumably by making Blue Cross coverage

(footnote continued)

trust laws,' " any buyer—regardless of its size—" 'is encouraged . . . to remain responsive to the needs and demands of its customers.' " *U.S.F.L. v. N.F.L.*, 842 F.2d 1335, 1361 (2d Cir. 1988) (affirming jury instructions *in haec verba*). Remaining responsive to such "needs"—in the complaint's words, making its coverage "attractive and desirable" to subscribers—is precisely what Blue Cross is alleged to have done.

3. This Basic Bears with Especial Force in the Regulated Context Within Which Empire Functions.

In the State of New York, the number and sorts of persons covered by Blue Cross—the bases for whatever percentage of hospital revenues, or market share, for which Blue Cross accounts—are the function of State policy as to what individuals Blue Cross must cover, plus the legislatively enacted "differential" that enables it to do so.[10] Such State role disables whatever finding of "anticompetitive" conduct or design may

---

less valuable) . . . . Whether or not Mr. Lovett is correct, this statement alone is not probative of any unlawful conduct on the part of Blue Cross. Even if this remark showed an intention on Mr. Lovett's or Blue Cross' part to limit competition, "an admitted intention to limit competition will not make illegal conduct that we know to be pro-competitive or otherwise immune from antitrust control." 7 Areeda, *supra*, ¶ 1506 at 391.

10 Specifically, New York law requires prior approval as to form and content by the Superintendent of Insurance before Blue Cross can "enter into a subscriber contract for hospital or medical coverage." (JA 14, ¶ 5.) *See* N.Y. Ins. Law § 4308(a). The same goes "for the 'schedule of the premiums or if appropriate rating formula from which premiums are determined, to be paid under the contracts.' " (JA 14, ¶ 6.) *See* N.Y. Ins. Law § 4308(b). Indeed, prior to "any proposed community rate increase for hospital and medical coverage," the law requires a public hearing. (JA 14, ¶ 7.) *See* N.Y. Ins. Law § 4308(c). As the New York State Council on Health Care Financing put it in its April 1987 Report (at 3):

> New York State in terms of health care has been the most highly regulated state in the nation. (JA 13, ¶ 3 (footnote omitted).)

be required to make out monopolization under Sherman Act § 2. *See, Aspen Skiing Co. v. Aspen Highlands Skiing Corp., supra*, 472 U.S. at 602.

It is the State, for example, that obliges Blue Cross to cover—at the same community rate, without prior physical examination, and at a substantial underwriting loss—large population segments such as individuals, small groups and the elderly (JA 19 n.4; JA 18, ¶ 16), persons that other insurers shun. (JA 18, ¶ 15.) Blue Cross is further obliged by the State to subsidize coverage of such persons out of its revenues from experience-rated group business for which it competes with other insurers. (JA 21-22, ¶¶ 24, 25.)

However, Blue Cross coverage of those without otherwise adequate insurance, as well as of experience-rated groups, is enabled only by the legislatively decreed "differential" which allows Blue Cross to purchase hospital services on behalf of all its subscribers at rates lower than commercial insurers. (JA 20, ¶ 22.) As the Superintendent of Insurance put it:

> Under the current system, Blue Cross/Blue Shield Plans are enrolling a substantial number of persons who are unable or least able to obtain health insurance coverage. The Blue Cross/Blue Shield Plans are able to do this because of the current hospital discount. (JA 20, ¶ 22.) (Emphasis omitted.)

From this it follows that it is State action and State policy—not anticompetitive or exclusionary design on the part of Blue Cross—that account for Blue Cross' present market posture.

In any event, it is the State that prescribes the price which Blue Cross pays for services at each member hospital. Thus, after reviewing the history of the present system for State regulation of Blue Cross' reimbursement, the State Department of Health concluded (JA 128, ¶ 14):

> ***This means that Blue Cross can pay hospitals neither more nor less than the rate established by state law, as determined by the Department. As a practical matter, then, Blue Cross can neither bargain for a lesser rate nor pay a higher rate than the state approved rate of payment.*** **(Emphasis added.)**

Such State control over price is key. For market share, the strength of existing and potential competitors, as well as the nature of the consuming buyers, are all relevant under Sherman Act § 2 to but a single end—to determine whether a firm possesses power over price in the relevant market. Indeed, "[m]onopoly power is the power to control prices or exclude competition." *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391 (1956) (footnote omitted). Since "[i]t is inconceivable that price could be controlled without power over competition" (*id.* at 392), inquiry under Sherman Act § 2 begins and ends with the State's control over price in the relevant market—the payment of monies to hospitals for patient care.

4. Whether a Particular Hospital Official May Like or Dislike Present Arrangements with Blue Cross Likewise Should Make No Difference.

Whether a given hospital might make more or less money under a different arrangement with Blue Cross ought make no difference because each member hospital has long ago agreed to accept State-set reimbursement from Blue Cross as payment in full for hospital services rendered patients covered by Blue Cross. Despite petitioners' efforts to generate confusion as to hospitals' obligations to Blue Cross or Blue Cross' obligations to its subscribers,[11] all parties have long and well understood

---

11 For example, petitioners point to Empire's arrangement covering New York State employees and their dependents (Petition at 7-8) to suggest some confusion on this score. Just to the contrary, however, the Empire Officer responsible for "all facets of claims processing, marketing, advertising and customer service for" that account has made clear below that

> [t]he Master Group Contract itself, a copy of which is *not* attached to Plaintiffs' [papers] . . . specifically provides that "Hospital Service shall comprise and mean . . . X-ray examinations, therapy and radioactive isotopes." (Article V, Par. 2(j)). . . .
>
> [T]he two parties to Blue Cross' hospital insurance subscriber agreement for New York State government employees . . . have both consistently interpreted their agreement as *including* professional non-interventional inpatient diagnostic and therapeutic

(footnote continued)

their respective obligations. These cannot now be held illegal and thus avoided simply because a hospital administrator now believes some other arrangement might leave his hospital better off financially.[12]

Particularly so since Blue Cross' relations with almost two-thirds of the member hospitals the complaint mentions have endured for almost half a century, and with practically all of them for three decades or more. The State of New York has stated its interest in preserving Blue Cross' comprehensive benefit coverage which such hospital arrangements have enabled. In the words of New York's Superintendent of Insurance (JA 23-24, ¶¶ 31-33):

> One consumer benefit of this policy has been that payments by subscribers for inpatient radiological diagnostic services have been kept under state regulation. Such policy is thus consistent with a major regulatory goal of this state to hold down increasing costs of inpatient care.
>
> * * *
>
> [Further,] [i]f direct billing by radiologists is permitted where, as here, such services have been included in hospital coverage, it could result in the unbundling of an inpatient hospital benefit package which is now subject to state

---

radiological services as a covered hospital service in Downstate New York. (JA 716-17.)

12 This argument harks back to the bases for enactment of New York's rigorous program for control over hospital costs:

> [t]he Legislature found that hospital costs were rising at an alarming rate and were attributable in large part to continued pressure for unnecessary duplication of facilities and inefficient management.

Presbyterian Hosp. v. Ingraham, 48 A.D.2d 491, 492, 369 N.Y.S.2d 738, 739 (1st Dep't 1975), *aff'd*, 39 N.Y.2d 867, 386 N.Y.S.2d 217, 352 N.E.2d 135 (1976) (citation omitted).

In the words of New York's Court of Appeals, the upshot was:

> ballooning hospital costs spawned only in part by inflation but mostly by hospital excesses in a reimbursed non-profit setting. . . .

Presbyterian Hosp. v. Ingraham, 39 N.Y.2d 867, 869, 386 N.Y.S.2d 217, 218, 352 N.E.2d 135, 136 (1976).

> regulation for the purpose of controlling hospital costs and thereby subscriber premiums.[13]

The views of such State officers appear worthy of consideration. Since the McCarran-Ferguson Act (15 U.S.C. § 1011 *et seq.*) leaves regulation of the "business of insurance" to the several states, courts

> start with a reluctance to disturb the state regulatory schemes that are in actual effect, either by displacing them or by superimposing federal requirements on transactions that are tailored to meet state requirements. When the States speak in the field of "insurance," they speak with the authority of a long tradition.

SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 68-69 (1959).

CONCLUSION

The petition for a writ of certiorari should be denied.

January 10, 1990

Respectfully submitted,

Robert A. Bicks
Counsel of Record
Howard S. Wolfson
BREED, ABBOTT & MORGAN
153 East 53rd Street
New York, New York 10022
(212) 888-0800

Attorneys for Respondent

---

13 The New York State Department of Health has similarly concluded that "such inclusion effectuates the State goal of cost containment" (JA 129, ¶ 17).

No. 89-941

JAN 12 1990

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,
Petitioners,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF OF THE AMERICAN COLLEGE OF RADIOLOGY AND THE AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

THOMAS W. GREESON
American College of Radiology
1891 Preston White Drive
Reston, VA 22091
(703) 648-8906

KIRK B. JOHNSON
EDWARD B. HIRSHFELD
MICHAEL L. ILE
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
(312) 645-5000

PAUL G. GEBHARD *
JENNER & BLOCK
One IBM Plaza
Chicago, IL 60611
(312) 222-9350

DAVID W. DEBRUIN
JENNER & BLOCK
21 Dupont Circle, N.W.
Washington, D.C. 20036
(202) 223-4400
Counsel for Amici

January 12, 1990

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-941

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,
Petitioners,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The American College of Radiology and the American Medical Association respectfully move for leave to file the attached brief *amicus curiae.* Petitioners have consented to the filing; respondent has not.[1]

---

[1] Respondent refused to consent unless the *amicus* brief contained specific statements concerning the involvement of the local chapter of the American College of Radiology in the proceedings below. The specific statements demanded by respondent are potentially misleading. This same issue was litigated in the Second Circuit, which granted a contested motion of the American College of Radiology to participate as *amicus curiae.* In any event, respondent does not appear to have any objection to the participation here of the American Medical Association. (Copies of the letters from both petitioners and respondent are on file with the Clerk.)

The American College of Radiology is a not-for-profit professional association of approximately 20,000 physicians who are specialists in radiology.[2] The purposes of the College are to advance the science of radiology, improve radiologic service to the patient, study the socioeconomic aspects of the practice of radiology, and encourage improved and continuing education for radiologists and allied professionals.

The American Medical Association ("AMA") is a private, voluntary nonprofit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and the improvement of the public health. Its membership exceeds 280,000 physicians and medical students.

Amici are dedicated to promoting the public welfare through the maintenance of appropriate professional standards and the provision of quality health care. A competitive market is essential to the efficient delivery of the health care services needed by the public. Preservation of competition in the marketplace depends upon vigorous enforcement of the antitrust laws. *Amici* believe that the Court of Appeals' decision in this case inappropriately permits harm to the competitive process in violation of those laws.

The decisions of the courts below have nationwide ramifications with respect to the ability of dominant medical insurers to use their market power to insulate themselves from price competition in the markets in which they purchase services for their subscribers. Respondent in this proceeding, Empire Blue Cross and Blue

---

[2] Diagnostic radiologists make expert interpretations of studies made under their direction, including radiographs, fluoroscopies, ultrasound and nuclear radiology scans, computerized tomographic ("CT") and magnetic resonance imaging ("MRI") studies. These interpretations often form the primary basis for definitive medical treatment. Therapeutic radiologists treat, and in many cases cure, malignancies.

Shield, possesses such market power, and it is the position of *amici* that respondent has abused that market power through the practice at issue in this case. If adopted by other courts, the Court of Appeals' decision could lead to similar harm to physicians and the public elsewhere. *Amici* seek to participate in this proceeding to urge the Court to grant the petition for certiorari and to restrain respondent's improper exercise of market power.[3]

For all the foregoing reasons, *amici* urge the Court to accept and file the attached brief *amicus curiae*.

Respectfully submitted,

THOMAS W. GREESON
American College of Radiology
1891 Preston White Drive
Reston, VA 22091
(703) 648-8906

KIRK B. JOHNSON
EDWARD B. HIRSHFELD
MICHAEL L. ILE
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
(312) 645-5000

PAUL G. GEBHARD *
JENNER & BLOCK
One IBM Plaza
Chicago, IL 60611
(312) 222-9350

DAVID W. DEBRUIN
JENNER & BLOCK
21 Dupont Circle, N.W.
Washington, D.C. 20036
(202) 223-4400
Counsel for Amici

January 12, 1990

* Counsel of Record

---

[3] These same concerns, and a legitimate, direct interest in the ability of radiologists to be free to offer their services in a competitive environment, have motivated the local chapter of the American College of Radiology to serve as an organizational vehicle for petitioners in identifying counsel for and funding this action.

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICI	1
INTRODUCTION	1
REASONS FOR GRANTING THE WRIT	6
I. THE DECISIONS BELOW IGNORE THE CRITICAL DISTINCTION ESTABLISHED BY THIS COURT BETWEEN UNILATERAL AND COLLECTIVE ACTION AND ENDORSE AN IMPROPER EXERCISE OF MARKET POWER	7
II. THE COURT SHOULD GRANT THE PETITION TO RESOLVE THE CONFLICT IN THE CIRCUITS OVER THE LEGALITY OF MONOPOLY "LEVERAGING"	13
CONCLUSION	16

TABLE OF AUTHORITIES

Cases: Page

Albrecht v. Herald Co., 390 U.S. 145 (1968) 12
Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) 13
Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585 (1985) 14
Association of Intercollegiate Athletics for Women v. National Collegiate Athletic Assn., 735 F.2d 577 (D.C. Cir. 1984) 15
Barry v. Blue Cross of California, 805 F.2d 866 (9th Cir. 1986) 10
Berkey Photo v. Eastman Kodak Co., 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980) 14
Brillhart v. Mutual Medical Insurance, 768 F.2d 196 (7th Cir. 1985) 9
Calnetics Corp. v. Volkswagen of America, Inc., 532 F.2d 674 (9th Cir.), *cert. denied*, 429 U.S. 940 (1976) 12
Catlin v. Washington Energy Co., 791 F.2d 1343 (9th Cir. 1986) 15
Consul v. Transco Energy Co., 805 F.2d 490 (4th Cir.), *cert. denied*, 481 U.S. 1050 (1986) 15
Eastern States Retail Lumber Dealers' Assn. v. United States, 234 U.S. 600 (1914) 12
Fishman v. Estate of Wirtz, 807 F.2d 520 (7th Cir. 1986) 15
Grenada Lumber Co. v. Mississippi, 217 U.S. 433 (1910) 12
Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979) 10
Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2 (1984) 8, 9
Kartell v. Blue Shield of Massachusetts, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) 9, 11, 13
Kerasotes Michigan Theatres v. National Amusements, 854 F.2d 135 (6th Cir. 1988) 15
Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959) 7

TABLE OF AUTHORITIES—Continued

	Page
Lorain Journal Co. v. United States, 342 U.S. 143 (1951)	14
Mandeville Island Farms v. American Crystal Sugar Co., 334 U.S. 219 (1948)	8, 12
Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut, 675 F.2d 502 (2d Cir. 1982)	9
Royal Drug Co. v. Group Life and Health Insurance Co., 737 F.2d 1433 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985)	10
United States v. Paramount Pictures, Inc., 334 U.S. 131 (1948)	12
Westchester Radiological Associates v. Empire Blue Cross and Blue Shield, 659 F. Supp. 132 (S.D.N.Y. 1987)	5
Westchester Radiological Associates v. Empire Blue Cross and Blue Shield, 707 F. Supp. 708 (S.D.N.Y. 1989)	*passim*
Westchester Radiological Associates v. Empire Blue Cross and Blue Shield, 884 F.2d 707 (2d Cir. 1989)	5
Miscellaneous:	
Radiology Practice Survey, American College of Radiology, Reston, Va. (1983)	2
Radiology Billing Practice Survey, American College of Radiology, Reston, Va. (1987)	3
R. Posner & F. Easterbrook, *Antitrust* 4-10, 148-150 (1981)	12

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-941

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., *et al.*,
Petitioners,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

BRIEF OF THE AMERICAN COLLEGE OF RADIOLOGY AND THE AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF AMICI

The interest of *amici* is described in the accompanying Motion for Leave to File Brief *Amicus Curiae*.

INTRODUCTION

Since the late 1960s, radiologists—like anesthesiologists, pathologists, and other medical specialists who typically provide services in hospital settings—increasingly have offered their services as independent contractors, rather than as hospital employees. A study performed for the American College of Radiology in 1983 found that 80.3% of all practicing radiologists were compensated

primarily on a fee-for-service basis, while only 2.8% were reliant primarily upon either a percentage or a lease arrangement with a hospital.[1] In those cases in which a radiologist establishes an independent practice, bills for radiology services generally are paid by insurers that offer coverage for the services of *physicians*, rather than by insurers that offer coverage for *hospital* services.

Respondent Empire Blue Cross and Blue Shield is a health insurance corporation offering services in portions of New York. Empire offers two basic insurance plans: "Blue Cross," which covers certain defined *hospital* services and benefits, and "Blue Shield," which covers medical services provided by *physicians*.[2] Over 80% of the approximately 11 million people who live in the 17 counties in the metropolitan New York City area subscribe to respondent's "Blue Cross" insurance plan for hospital services. In contrast, less than a third of those 11 million people subscribe to respondent's "Blue Shield" plan for physician services, and instead subscribe to other medical insurers.

At issue in this case is an arrangement through which respondent obtains professional radiology services for Blue Cross subscribers in the 17 downstate counties. In essence, if a hospital wishes to be eligible to treat Blue Cross subscribers and to receive reimbursement from respondent, the hospital (1) must agree to accept an established payment from Blue Cross as full reimbursement for the covered services provided, and (2) must

---

[1] *Radiology Practice Survey 1983*, American College of Radiology, Reston, Va. (1983). Although 17% of the practicing radiologists received salary compensation, 80% of these physicians were employed in government hospitals or other facilities in which patients do not pay for professional services.

[2] "Blue Cross" and "Blue Shield" simply are types of insurance coverage offered by respondent. They are not separate economic entities; they do not represent different divisions or departments within the company.

agree to include the professional services of radiologists within those covered services paid (exclusively) by Blue Cross.

No other Blue Cross plan in the country requires the professional services of radiologists to be included in the services provided to hospital inpatients. Similarly, the Blue Shield policy provided by respondent is the only insurance plan offered by a private insurance carrier offering general coverage for physicians' services (including other Blue Shield plans) that does not include coverage for the professional services of radiologists to hospital inpatients. In other words, so far as *amici* are aware, respondent is the only health benefit insurer in the country that insists on covering professional radiology services as part of a *hospital* benefit insurance plan.[3]

Through the billing arrangement at issue here, respondent merges the distinct product markets in this locale for hospital and radiology services. In the words of the District Court, "Blue Cross insists that hospitals that contract with Blue Cross continue to offer radiology services to Blue Cross subscribers as part of a *package* of hospital services." *Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 707 F. Supp. 708, 710 (S.D.N.Y. 1989) (emphasis supplied), *reprinted in* Petitioners' Appendix ("A") at A-6, A-9. *See also* 707 F. Supp. at 710 (A-10) (Blue Cross "us[es] its bargaining power to purchase radiology services as part of a *bundle* of hospital services") (emphasis supplied). As

---

[3] A 1987 survey conducted by the American College of Radiology of insurance practices in all 50 states revealed that in no state other than New York did any insurer, including other Blue Cross and Blue Shield providers, attempt to prohibit radiologists from establishing an independent practice and billing a patient (or the patient's *physician* service insurer) for professional services. *Radiology Billing Practice Survey*, American College of Radiology, Reston, Va. (1987).

summarized by the court:

> [I]f [the hospitals] wish to sell to Blue Cross, they must sell Blue Cross the package it wants to buy, and they must agree that the price charged to Blue Cross will be the only charge for the services.

707 F. Supp. at 713 (A14).

Blue Cross is able to secure this arrangement only through its dominant position as the insurer for most hospital service claims. Hospital executives testified that, although they would prefer not to include radiology services as covered *hospital* services, they have no choice but to accede to Blue Cross' demands.[4] Indeed, the hospitals rejected requests for similar arrangements made by other, smaller insurers.[5]

The "bundling" arrangement compelled by Blue Cross through use of its monopoly power has two significant effects. First, in the competitive market for the sale of insurance to cover claims for physician services—which is equivalent to the competitive market for "the opportunity to buy" such services on behalf of subscribers—respondent is able to use its dominant position in the market for *hospital* services to secure a virtually exclusive franchise to provide coverage for radiology services that it otherwise could not obtain. Second, radiologists are foreclosed from selling their services in a more competi-

[4] Evidence in the record establishes that hospitals prefer radiologists, and other hospital-based physicians, to practice as independent contractors because (1) the hospital no longer has to pay a salary to the physician, (2) the fee income generated by the physician is utilized in part to buy equipment for the hospital, and (3) the hospital is better able to attract and retain qualified physicians. (J.A. 430-31). Respondent admitted below, however, that, if a hospital did not accept the demanded "bundling" arrangement for radiology services, respondent would invoke "sanctions," including terminating the hospital as a Blue Cross participant or cutting off the hospital's cash flow. (J.A. 714.54). Hospitals acknowledged they are coerced by this threat. (J.A. 476-82, 489, 493, 497).

[5] *See* 707 F. Supp. at 713 n.10 (A-15).

tive market—the market for *physicians'* services, in which many "buyers" compete—and instead must provide their services in a market in which one buyer is dominant.

The District Court upheld this arrangement on essentially two grounds, and the Court of Appeals affirmed for the same reasons.[6] With respect to petitioners' Sherman Act § 1 (15 U.S.C. § 1) challenge to respondent's agreement with the hospitals, the District Court ruled that this case was no different from any situation in which a dominant buyer *unilaterally* used its bargaining power to drive a "hard bargain" with a seller.[7] That respondent does not, in fact, act unilaterally, and instead uses its power over the hospitals to secure an arrangement with radiologists that it could not obtain itself, made no difference to the court:

> [T]here is no authority whatever for the proposition that a seller has an *anti-trust* remedy where a buyer insists upon buying his services through an intermediary.

707 F. Supp. at 712-13 (A-14) (emphasis in original).

Second, the District Court rejected petitioners' claims, predicated on § 2 of the Sherman Act (15 U.S.C. § 2),

---

[6] There are two inconsistent opinions of the District Court in this case, by two different judges. The judge to whom the case originally was assigned denied respondent's motion to dismiss, *Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 659 F. Supp. 132 (S.D.N.Y. 1987) (A-26), on grounds later rejected by a subsequent judge ruling on respondent's motion for summary judgment. *See Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 707 F. Supp. 708, 712 n.8 (S.D.N.Y. 1989) (A-6, A-14). The Court of Appeals affirmed on the basis of the second judge's opinion. *Westchester Radiological Associates v. Empire Blue Cross and Blue Shield*, 884 F.2d 707 (2d Cir. 1989) (A-3).

[7] *See* 707 F. Supp. at 713 (A-16) ("Blue Cross is simply acting as a rational buyer attempting to get the best possible terms for its subscribers.")

that respondent was using its market power in the hospital service market improperly to maintain its monopoly in that market (by enhancing the attractiveness of its Blue Cross coverage), and as "leverage" to secure an unlawful competitive advantage in *another* market (the physician service insurance market). The court again ruled that respondent had not used its market power in the hospital service market improperly, and it rejected petitioners' monopoly "leveraging" argument on the ground that, by essentially withdrawing radiology services from the physician service insurance market altogether, respondent had not used its bargaining power to gain any unfair advantage in that market.[8]

REASONS FOR GRANTING THE WRIT

There are two important reasons why this Court should grant the petition for certiorari. First, the decisions of the courts below represent a collision of two importantly distinct lines of antitrust authority: a line firmly prohibiting agreements designed to merge or "bundle" two distinct product markets at the expense of fair competition in those markets, and a line generally permitting a dominant buyer's *unilateral* use of its market power to achieve a favorable bargain in the marketplace. While respondent lawfully may be entitled to drive any bargain it unilaterally can reach with either the hospitals or the radiologists (subject only to restraints against predatory conduct or abuse of market power), it may not combine with *other* parties (here, the hospitals), and compel *them* to secure an agreement with the radiologists that respondent could not obtain itself. The question of law presented is important and unsettled—as evidenced by the two inconsistent opinions of the District Court in this very case—and should be resolved by this Court.

---

[8] *See* 707 F. Supp. at 716 (A-21) ("Blue Shield's competitors benefit from Blue Cross' policy as much as does Blue Shield—none of them pays for radiology services for patients with Blue Cross coverage.")

Second, this case presents the important question of the lawfulness, under § 2 of the Sherman Act, of a monopolist's use of its market power in *one* market to obtain a distinct competitive advantage—but not necessarily a monopoly—in another market. The Courts of Appeals are sharply divided over the lawfulness of so-called monopoly "leveraging." This Court should grant the petition to resolve this important conflict.

I. THE DECISIONS BELOW IGNORE THE CRITICAL DISTINCTION ESTABLISHED BY THIS COURT BETWEEN UNILATERAL AND COLLECTIVE ACTION AND ENDORSE AN IMPROPER EXERCISE OF MARKET POWER.

The District Court essentially ruled that the allegations in the complaint failed to state a claim under the antitrust laws.[9] Thus, the court saw no conceivable antitrust violation in the "bundling" arrangement demanded by respondent and compelled solely through its monopoly power in the hospital service insurance market.

The potential anti-competitive impact of this type of business arrangement—which can be characterized both as a type of group boycott and as a tying arrangement—is firmly established in this Court, subject in certain circumstances even to *per se* prohibition. For example, in *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959), the Court held that a complaint that the defendant had used "monopolistic buying power" to bring about a concerted refusal by manufacturers and distributors to deal with the plaintiff stated a claim under the antitrust laws. The Court emphasized:

> This is not a case of a single trader refusing to deal with another, nor even of a manufacturer and a

[9] Although the court granted respondent's motion for summary judgment, it ruled that the judge to whom the case originally was assigned erred in denying respondent's motion to dismiss for failure to state a claim. See 707 F. Supp. at 712 n.8 (A-14).

> dealer agreeing to an exclusive distributorship. Alleged in this complaint is a wide combination consisting of manufacturers, distributors and a retailer.

359 U.S. at 212-213 (footnote omitted).[10] Similarly, in *Jefferson Parish Hospital District No. 2 v. Hyde*, 466 U.S. 2, 13-14 (1984), this Court noted that it had condemned "tying" arrangements in which a seller had used "some special ability—usually called 'market power'—to force a purchaser to do something that he would not do in a competitive market."

The "bundling" requirement at issue here has attributes of each of these condemned agreements. Respondent has used its "monopolistic buying power" to coerce hospitals to refuse to deal with radiologists who insist on practicing as "independent contractors" when treating Blue Cross subscribers and who thereby would "sell" their services in the more competitive *physician* service insurance market. Respondent's use of the hospitals, over which it exercises substantial control,[11] to secure this arrangement is critical: respondent lacks sufficient power over the *radiologists* to achieve the same result directly. The hospitals, on the other hand, provide facilities essential to the radiologists.

Similarly, respondent's insistence on "bundling" hospital services and professional radiology services has all the characteristics of an improper "tying" agreement. In *Jefferson Parish*, this Court recognized that distinct product markets exist for hospital services and the services of anesthesiologists, 466 U.S. at 22-25; the same conclusion is inescapable for the professional services of

---

[10] *See also Mandeville Island Farms v. American Crystal Sugar Co.*, 334 U.S. 219 (1948) (allegation of a conspiracy among large buyer/refiners of sugar beets to set purchase prices stated a claim under the Sherman Act).

[11] *See* n.4, *supra*.

radiologists.[12] While an invalid "tying" arrangement was *not* found in *Jefferson Parish* because consumers had the option of going to another hospital, and thus were not "forced" to purchase the tied product, in this case respondent has used its market power to coerce *all* hospitals in the downstate New York area to bundle hospital and radiology services. As a result, the business of insuring radiology claims is provided *only* by respondent; other insurers virtually are foreclosed from the market.[13]

The District Court did not perceive the blatant impropriety of respondent's "bundling" arrangement because it believed this case to be indistinguishable from a series of cases rejecting challenges by physicians to "balance billing" prohibitions imposed by major insurers. 707 F. Supp. at 711 (A-11); *see e.g., Medical Arts Pharmacy v. Blue Cross & Blue Shield of Connecticut*, 675 F.2d 502 (2d Cir. 1982); *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985); *Brillhart v. Mutual Medical Insurance*, 768 F.2d

---

[12] Moreover, just as "distinct product markets" within the meaning of *Jefferson Parish* exist for hospital services and certain hospital-based physician services (such as professional radiology services), distinct product markets exist for the *insurance* of claims for hospital services and these physicians' services. Indeed, respondent is a dominant provider in one market, while substantial competition exists in the other.

[13] Respondent's merger of hospital and radiology services comes at the expense of both other insurers of *physician* services, who are foreclosed from the business of insuring claims for radiology services, and radiologists, who legitimately would benefit from the ability to offer their services in a market with more than one "buyer." Indeed, the obvious impropriety of respondent's "bundling" arrangement is evidenced by the fact that no other insurance carrier in the country "bundles" hospital and radiology services and thereby attempts to block radiologists from practicing as independent contractors. *See* n.3, *supra*.

196 (7th Cir. 1985); *Barry v. Blue Cross of California*, 805 F.2d 866 (9th Cir. 1986).[14]

In the "balance billing" cases, the insurer requires that, if a physician chooses to "participate" in the insurance program (and thereby receive the benefits of convenient access to a large client base and direct reimbursement from the insurer), the physician must agree to accept a limited, defined rate as full payment for the services provided. Two features of these arrangements are essential. First, the "balance billing" cases involve the *unilateral* exercise of bargaining power by a single major "purchaser" to obtain price concessions directly from physicians, who "sit on [the] opposite sid[e] of the bargaining table." *Royal Drug Co. v. Group Life and Health Insurance Co.*, 737 F.2d 1433, 1438 (5th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985). Second, a competitive market may continue to operate, in that, if the insurer sets the reimbursement rate too low, enough physicians ultimately will choose not to "participate"—even at the expense of a potential loss of a significant client base—and thereby deprive the program of its attractiveness to consumers.

Both of these features are absent in the instant case. Because respondent does not have market power over the radiologists, it has chosen not to negotiate directly with them to attempt to secure this business or the rate it desires. Rather, respondent has *combined with hospitals* and induced *them* to refuse to deal with any radiologist who will not forgo status as an independent practitioner. In addition, because respondent does not deal with or possess market power *over the radiologists*, petitioners have no opportunity to check that market power through the bargaining process.

---

[14] Cf. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

Other cases have recognized the crucial distinction between an insurer's *unilateral* exercise of bargaining power over physicians with whom it bargains, and improper *collective* action designed to achieve the same result.[15] Indeed, in this very case, the District Judge to whom the case originally was assigned rejected the "balance billing" cases because

> the buyer (Empire) has no contractual relations with the sellers (the Radiologists) and has not negotiated for any. Rather, the crucial agreement here, whereby Empire allegedly compels the hospitals to prevent the direct billing of Blue Cross subscribers for the Radiologists' diagnostic services, is between Empire and the hospitals, *not* Empire and the Radiologists.

659 F. Supp. at 135 (A-32). Similarly, the court in *Kartell v. Blue Shield of Massachusetts*, *supra*, distinguished the *unilateral* balance billing situation from a case in which an insurer acts as "a 'third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains." 749 F.2d at 924.

The District Court in this case rejected what it regarded as *Kartell*'s "jocular reference to a sinister 'third force.'" 707 F. Supp. at 712 (A-14). What the court failed to recognize is that it is this "third force" that converts *unilateral* to *concerted* action. And, as first es-

---

[15] This Court has never addressed the substantive antitrust issues raised in the "balance billing" cases, and, in particular, the potential limits on the *unilateral* exercise of market power by a dominant purchaser in the balance billing context. *See, e.g.*, discussion in *Kartell, supra*, 749 F.2d at 927-930. Because this case presents the type of concerted action that always has been unlawful under § 1 of the Sherman Act (and that may form the predicate for an "improper" use of monopoly power under § 2 of the Act), there is no need to consider here the proper limit on the *unilateral* exercise of market power.

tablished in an early antitrust decision of this Court, "[a]n act harmless when done by one may become a public wrong when done by many, acting in concert, for it then takes on the form of a conspiracy, and may be prohibited or punished, if the result be hurtful to the public, or to the individual against whom the concerted action is taken." *Grenada Lumber Co. v. Mississippi*, 217 U.S. 433, 440-41 (1910); *see also Eastern States Retail Lumber Dealers' Assn. v. United States*, 234 U.S. 600, 614 (1914).[16]

This case is not about petitioners' right to balance-bill patients. What is at issue here is concerted action in which respondent uses its market power over *hospitals* to garner insurance business in another market that it could not obtain on the merits. That arrangement harms other insurers competing for business in that market, it harms radiologists who are foreclosed from offering their services in a competitive environment, and it ultimately may harm consumers.[17]

---

[16] A finding of concerted action is not foreclosed here because the hospitals may have acted involuntarily. *United States v. Paramount Pictures, Inc.*, 334 U.S. 131, 161 (1948); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968); *Calnetics Corp. v. Volkswagen of America, Inc.*, 532 F.2d 674, 682 (9th Cir.), *cert. denied*, 429 U.S. 940 (1976).

[17] In rejecting petitioners' antitrust claims, the District Court placed undue reliance on a statement by petitioners that radiologists could obtain an additional $25 million, at the expense of consumers, if not for respondent's "bundling" requirement. There is no guarantee, of course, that any "favorable bargain" improperly achieved by respondent will be passed on to consumers. *See* R. Posner & F. Easterbrook, *Antitrust* 4-10, 148-150 (1981). If $25 million is the amount of money petitioners legitimately could obtain in a competitive market of many insurer/buyers, rather than a market *improperly* dominated by a single insurer/buyer, the antitrust laws do not foreclose relief. In *Mandeville Island Farms v. American Crystal Sugar Co.*, *supra*, the Court held that a conspiracy among large buyer/refiners of sugar beets to fix purchase prices to the detriment of seller/growers stated a cause of action under § 1 of the Sherman Act, despite the fact that "the persons specially injured . . . are sellers, not customers or consumers," 334 U.S. at

This Court should grant the petition to resolve the confusion in this important area of law, evidenced by the two conflicting decisions of the District Court in this very case, as well as by the inconsistency of this case with *Kartell v. Blue Shield of Massachusetts*, *supra*. In addition, the Court should not allow respondent's novel "bundling" requirement, and the erosion permitted by the courts below on the distinction between unilateral and collective action, to become entrenched.

II. THE COURT SHOULD GRANT THE PETITION TO RESOLVE THE CONFLICT IN THE CIRCUITS OVER THE LEGALITY OF MONOPOLY "LEVERAGING."

Apart from the § 1 issue presented by respondent's agreement with and use of the hospitals to coerce radiologists to provide their services to Blue Cross subscribers only through hospitals, this case presents important questions concerning the permissible use of market power under § 2 of the Sherman Act. It is indisputed that respondent was able to secure its "bundling" arrangement only through its market power in the *hospital* service insurance market. It did so for either (or both) of two reasons: either to maintain its monopoly in the hospital service insurance market, or to secure business in the *physician* service insurance market that it could not obtain on its own merits.[18] Use of market power for either reason is unlawful.

235, and the reduced purchase prices could have benefited consumers. Similarly, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), this Court held that a schedule of *maximum* fees set by competing physicians constituted a *per se* violation of the Sherman Act, rejecting the claim that a maximum fee schedule only could benefit consumers. *Id.* at 348.

[18] Minutes of respondent's board meetings disclose that its "bundling" requirement was motivated solely by concern that any other practice would "reduce the value of our product and imperil our market share." (J.A. 555). As further stated in the minutes:

It is firmly established under § 2 of the Sherman Act that a monopolist may not use improper means to maintain an existing monopoly lawfully acquired. *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985); *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951). In this case the District Court assumed that "Blue Cross uses its market power to obtain favorable prices from hospitals," 707 F. Supp. at 715 (A-20), but, again relying erroneously on the balance billing cases, it viewed respondent merely as a buyer negotiating a good price or specifying what it would buy. *Id.* A similar question is presented under § 2, therefore, as that presented under § 1: is respondent's coercive use of the *hospitals* to obtain agreements with *physicians* that respondent could not otherwise obtain a proper use of monopoly power?

This case also presents a distinct and important question under § 2 of the Sherman Act. Respondent has used its monopoly in the hospital service insurance market to obtain a virtually exclusive franchise to provide coverage for professional *radiology* services, which in all other parts of the country is provided by insurers of *physicians'* services in a competitive payor marketplace. Thus, respondent has used its monopoly in one market to gain a distinct and substantial advantage that it otherwise would not enjoy—but not necessarily a monopoly—in another, competitive market.

There is authority that such monopoly "leveraging" is unlawful. In *Berkey Photo v. Eastman Kodak Co.*, 603 F.2d 263, 276 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980), the court unequivocally stated:

> [T]he use of monopoly power attained in one market to gain a competitive advantage in another is a violation of § 2, even if there has not been an attempt

---

"The ultimate question comes down to whether we can continue to include these costs under the Blue Cross contract or abandon the field [of medical insurance] to others?" *Id.*

> to monopolize the second market. It is the use of economic power that creates the liability.

This principle more recently was expounded in *Kerasotes Michigan Theatres v. National Amusements*, 854 F.2d 135 (6th Cir. 1988). The court firmly accepted the proposition that, "[t]o run afoul of the antitrust laws, it is not necessary that the party attempting to leverage its monopoly power from a given market into a second market possess monopoly power or a dominant market position in that second market," *id.* at 137, and explained:

> Products that may be inferior should not be allowed to prosper in a particular market as a result of its producer's exploitation of its monopoly position in a second market. Under such situations, potential economic or competitive gains are not identifiable.

Id. at 138.

Other circuits, however, have explicitly questioned or repudiated this doctrine. *See Catlin v. Washington Energy Co.*, 791 F.2d 1343, 1346 (9th Cir. 1986); *Fishman v. Estate of Wirtz*, 807 F.2d 520, 541 n.18 (7th Cir. 1986); *Association of Intercollegiate Athletics for Women v. National Collegiate Athletic Assn.*, 735 F.2d 577, 586 n.14 (D.C. Cir. 1984); *Consul v. Transco Energy Co.*, 805 F.2d 490, 494 & n.11 (4th Cir.), *cert. denied*, 481 U.S. 1050 (1986).

The District Court in this case denied that any monopoly "leveraging" was present. It concluded that "Blue Shield's competitors benefit from Blue Cross' policy as much as does Blue Shield—none of them pays for radiology services for patients with Blue Cross coverage." 707 F. Supp. at 716 (A-21). There are two gross flaws with this analysis.

First, the court's analysis misperceives the identity of Blue Cross and Blue Shield—which merely are different products offered by a single entity, respondent. The point is that *respondent* benefits economically through the acquisition of insurance business it otherwise would lose in

the competitive physician service insurance market. Second, the court viewed respondent's action as providing equal cost *savings* to Blue Shield and other physician service insurers. If such cost savings indeed were a *benefit* to others—as perceived by the District Court—there would be no reason why respondent (through its Blue Cross coverage) voluntarily would inflict all such costs upon itself. The point here again is the garnishment of insurance business, which, while entailing *costs*, entails costs that presumably are recouped through other revenues.

This case thus presents a classic example of monopoly "leveraging." While respondent has not acquired a monopoly in the physician service insurance market, it has secured a greater *share* of that market *than it could obtain on the merits* through use of its monopoly power in the hospital service market. This Court should grant the petition to clarify the permissible use of monopoly power under § 2 of the Sherman Act, and in particular to resolve the express conflict existing in the circuits over the monopoly "leveraging" doctrine.

CONCLUSION

For all the foregoing reasons, and for those set forth in the petition for certiorari, the petition for certiorari should be granted.

Respectfully submitted,

THOMAS W. GREESON
American College of Radiology
1891 Preston White Drive
Reston, VA 22091
(703) 648-8906

KIRK B. JOHNSON
EDWARD B. HIRSHFELD
MICHAEL L. ILE
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
(312) 645-5000

PAUL G. GEBHARD *
JENNER & BLOCK
One IBM Plaza
Chicago, IL 60611
(312) 222-9350

DAVID W. DEBRUIN
JENNER & BLOCK
21 Dupont Circle, N.W.
Washington, D.C. 20036
(202) 223-4400
Counsel for Amici

January 12, 1990

* Counsel of Record